**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against:<br><br>FESTUS BAMIDELE DADA, M.D.<br>802 Magnolia Avenue, #203<br>Corona, CA 91719<br><br>Physician's and Surgeon's Certificate No. A 40801,<br><br>Physician Assistant Supervisor Approval No. SA 27600,<br><br>Respondent. | OAH NO. L-2001050313<br><br>CASE NO. 18-1999-101312 |

## DECISION AFTER REMAND FROM SUPERIOR COURT

This matter came on regularly for hearing before Roy W. Hewitt, Administrative Law Judge ("ALJ"), Los Angeles Office of Administrative Hearings, at San Diego, California on February 14, 15, 19, and 22, and March 19 and 20, 2002.

Deputy Attorney General Mary Agnes Matyszewski represented complainant.

Respondent, Festus B. Dada, M.D., personally appeared and was represented by Dr. Marvin Firestone, Esq.

Oral and documentary evidence was received and the matter was submitted on March 20, 2002.

On April 8, 2002, the administrative law judge submitted his proposed decision to the Division of Medical Quality of the Medical Board of California. The division declined to adopt that decision and issued its Decision After Nonadoption on August 30, 2002, to become effective on September 30, 2002.

Thereafter, respondent filed a Petition for Writ of Mandamus in Sacramento County Superior Court, Case No. 02CS01700. On April 13, 2003, the court issued its judgment in the matter, granting the petition in part and denying the petition in part. The Sacramento County Superior Court, pursuant to its Judgment and the Statement of Decision issued March 14, 2003, commanded the division to reconsider the penalty imposed in accordance with the court's direction in the Judgment and the Statement of Decision.

Having reconsidered the penalty pursuant to the court's direction, the board now makes a modified decision in compliance with the Judgment and with the Statement of Decision. A copy of the Judgment and of the Statement is attached as Exhibit "A" and incorporated herein by reference.

## FACTUAL FINDINGS

1. Ron Joseph filed the Accusation and the First Amended Accusation in his official capacity as the Executive Director of the Medical Board of California ("the board").

2. On April 23, 1984, the board issued Physician's and Surgeon's Certificate number A 40801, to respondent, Festus Bamidele Dada, M.D. Respondent's certificate was in full force and effect at all relevant times.

3. On August 27, 1997, the board issued Physician Assistant Supervisor Approval No. SA 27600 to respondent, Festus B. Dada. That approval was in full force and effect at all relevant times.

### Introduction

The allegations of the First Amended Accusation concern respondent's care, treatment and records concerning five separate patients. The allegations concerning each patient will be separately discussed in this Proposed Decision, under the appropriate heading.

### Patient Care

#### Patient W. D.:

4. On September 13, 1998, W. D., a 78 year-old male, was admitted to Inland Valley Regional Medical Center, Wildmar, California, with a chief complaint of generalized weakness. The following day, September 14, 1998, an x-ray revealed that W. D. had a large right pneumothorax with a slight mediastinal shift to the left side. The radiologist, Dr. Stapaciss, called respondent and discussed the case with him. At the time of the discussion respondent was performing surgery on another patient. It is unclear who was at fault, however, the radiologist either told respondent that the pneumothorax was on the left side, or respondent misunderstood the radiologist. Either way, respondent believed the

pneumothorax was on W. D.'s left side. Respondent finished his surgery, went "upstairs" and quickly evaluated W. D. Respondent relied on the information he received from the radiologist that the pneumothorax was on the left side. (Exhibit 36, pg. 5.) Then, at approximately 12:30 p.m., respondent "proceeded to put a chest tube on the left side." (Exhibit 36, pg. 2.) After placing the tube respondent "went downstairs" and looked at the x-ray. (Exhibit 36, pg. 2) Respondent was surprised when the x-ray revealed that the pneumothorax was on the right as opposed to the left. Respondent went back upstairs and told W. D. that he had made a mistake and had to get a tube in his right side. By this time W. D. was very short of breath. (Exhibit 36, pg. 2.) At approximately 1:40 p.m. respondent placed another tube in W. D.'s right side.

5. Fluid drained from the left tube, indicating a left pleural effusion. Accordingly, the left tube helped alleviate W. D.'s problem(s) and appropriately remained inserted until 3 days later. Notwithstanding the fact that fluids drained from the left tube, respondent's chart entries and documentation fail to note any x-ray evidence, physical examination evidence or any report of the observed drainage. Consequently, respondent's documentation is substandard.

6. On September 14, 1998 at 11:30 a.m., W. D. signed an "Authorization and Consent to Surgery" reflecting his consent to "Insertion of Chest tube". Later, respondent changed the consent form to conform to W. D.'s later, verbal, consent to insertion of the right tube by adding the letter "s" to the word "tube". The consent form now reads "Insertion of Chest tubes." (Exhibit 4, AGO 2993.) Respondent's unilateral changing of the wording in the consent form, signed by W. D. and witnessed by a third party is improper. Anyone reviewing the form at a later time would be mislead into believing that W. D. initially, at 11:30 a.m., consented to the placement of both tubes, rather than just one.

7. In addition to modifying the consent form, respondent also modified his written progress note by overwriting the word "left" with the word "bilateral". The September 14, 1998 progress report now reflects that right and left chest tubes were inserted due to "bilateral pneumothorax". This progress note is incorrect and misleading. The progress note "viewed in isolation" would lead one to believe that both tubes were placed at the same time, which they were not; that both tubes were planned initially, which they were not; and that W. D. had "bilateral pneuomothorax", which he did not (he had a right pneumothrax with left pleural effusion). (Exhibit 4, AGO 3029.)

8. Five days after the surgery respondent dictated an operative and consult report that stated:

> "The patient was placed on his bed. The right and left chest were prepared with Betadine and draped in a sterile fashion....two #28 chest tubes were inserted in the fourth intercostal space and secured in place...."

Again, this note is inaccurate and misleading, especially if read along with the consent form and hand-written progress note described in Findings 6 and 7, above. Additionally, there is no written documentation in W. D.'s chart that accurately describes what happened. The only reasonable conclusion that can be drawn is that respondent was trying to conceal his mistake by making all written records of the surgery suggest that the procedures performed were contemplated at the outset and that they were done together. In truth and fact, they were done over one-hour apart.

9. Professionals, who know and work, or have worked, with respondent, all agree that respondent is an excellent surgeon. Other doctors have even sent their family members to respondent for surgery. It was not established by clear and convincing evidence that respondent was grossly negligent and exhibited repeated negligent acts in his care and treatment of W. D.

Patient W. L.[1]

10. On May 5, 1998, patient W. L., an 86 year-old male, was admitted to Inland Valley Regional Medical Center. A consultation note made by respondent on May 5 indicates that W. L. was admitted to the hospital with fatty food intolerance, nausea and episodic abdominal pain radiating to the back.

11. A nurse prepared an "Initial Patient History Assessment" which stated that W. L. had undergone coronary artery bypass graft in 1980 and again in 1987. He had a pacemaker inserted in 1998. W. L. had blood pressure problems, cardiac arrhythmias and prior myocardial infarction. He had past fainting spells, suffered a stroke three years before, had edema of the extremities and experienced shortness of breath on exertion. W. L. was taking numerous medications, including Hydrolozine, Imdur, Lasix, Hytrin, Cordarone, Nitro patch, Synthroid, Inabsine, and Lanoxin. Laboratory results, dated May 5, 1998, show creatinine 3.5, serum digoxin 2.7, INR 1.2, PTT 30, platelet count 99,000. An abdominal ultrasound performed the same day was interpreted as showing gallstones.

12. Respondent had treated W. L. in the past and had spoken with W. L.'s internist. Consequently, respondent, W. L.'s admitting internist, and the anesthesiologist, knew W. L. had a history of heart problems, that he had undergone two previous bypass surgeries, and that he had a pacemaker in place. Respondent was also aware of the medications W. L. was taking. Respondent's chart entries, however, fail to mention any of this. Respondent only notes that W. L. had a history of degenerative joint disease, a morphine pump implanted and chronic renal insufficiency. For the review of systems respondent simply noted "negative".

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[1] At the hearing complainant moved to strike the allegations of paragraph 15, subdivisions C and D. Accordingly, the remaining allegations are that respondent was grossly negligent, repeatedly negligent and demonstrated incompetence due to his failure(s) to perform or document an adequate preoperative evaluation.

The physical examination notes that the chest and lungs were clear bilaterally, and as for cardiac, respondent merely noted "S1" and "S2".

13. A progress note by another physician indicates "dehydration, renal insufficiency, history of HTN, history of TIA, thrombocytopenia, compensated congestive heart failure, admit, see orders." Immediately following this progress note, respondent writes: "surgery 1. Cholelithiasis 2. history of DJD. Plan: lap. Chole. Possible laparotomy."

14. On May 6, 1998, respondent performed a laparoscopic cholecystectomy on W. L. The operative report does not reveal any intraoperative difficulties, the operation was rather routine. Several hours after the surgery W. L. was hypotensive, he was "pale, moaning, blood pressure 78/20, rule out post op. Bleed, to surgery ASAP."

15. W. L. was returned to the operating room and underwent a laparotomy. W. L. had 600 cc's of blood in the subhepatic space and was bleeding from an arterial vessel adjacent to the cystic duct. The bleeding was controlled by electrocautery. Toward the end of the procedure W. L. suffered cardiac arrest. Attempts at resuscitation and defibrillation were unsuccessful. The autopsy suggested that W. L. died of myocardial infarction.

16. W. L.'s eventual demise was extremely unfortunate, however, respondent was not at fault. Respondent's records, however, were deficient. Respondent failed to note his awareness of W. L.'s heart disease, the existence of the pacemaker, his awareness of the medications being taken by W. L., and the nature and extent of discussions with W. L. of the considerable risks of the surgery. As previously mentioned, W. L. was referred to respondent by his internist. Respondent spoke with the internist and the internist cleared W. L. for the surgery. Respondent did not naively care for W. L., and the death of this high-risk patient could have occurred in the best of hands.

Although respondent's preoperative evaluation of W. L. was appropriate and adequate, his documentation of the evaluation, and the factors considered, is deficient.

Patient A. R.:

17. Sometime prior to December 8, 1997, A. R. saw his internist, Dr. A. O. for the first time. Dr. A. O. took a medical history and performed a complete physical examination based on A. R.'s complaints of "continual abdominal pain" and "throwing-up" after meals. Dr. A. O. knew A. R. had diabetes, however, when asked about his drinking habits A. R. responded by stating that he only "drank on occasion." A. R. was stable, his glucose was reasonably controlled, there was "no severe disease process" at the time; his primary problem seemed to be gallstones. Dr. A. O. believed A. R. could tolerate surgery, therefore, Dr. A. O. recommended a surgical consultation with respondent for gallstone removal to prevent further complications.

18. On December 8, 1997, A. R. consulted with respondent. Respondent took a history and performed a physical examination. Respondent noted that A. R.'s chief complaint was "gallstones." A. R. was diabetic with "symptomatic gallstones"[2]. When asked about alcohol consumption A. R. claimed to only drink on occasion. A. R. was not on blood thinner.

After the consultation respondent called his internist, Dr. A. O.[3]. The two discussed A. R.'s condition and decided that a laparoscopic cholecystectomy was necessary and appropriate. Respondent asked A. R. when he wanted surgery. A. R. responded "yesterday". Respondent scheduled A. R. for surgery the next day and ordered blood tests, urinalysis, chest x-ray and EKG.

19. On December 9, 1997, A. R. was admitted to Inland Valley Regional Medical Center for a laparoscopic cholecystectomy. Respondent's written history and physical states that A. R. had recurrent abdominal pain with fatty food intolerance. Respondent documented that A. R. had asthma, diabetes, and ulcer disease. Medications listed included insulin and Brontex. As a result of the physical examination respondent documented that A. R. was normal except for his abdomen, which, had "upper quadrant tenderness, no masses". Respondent failed to list A. R.'s vital signs.

Respondent met with the anesthesiologist to discuss the lab work respondent had ordered the day before. The anesthesiologist showed respondent lab results from November 2, 1997 and told respondent that these test results were acceptable to him and that there was no reason not to proceed with the surgery. Respondent agreed. The lab results, which were obtained on November 2, 1997, revealed elevation of A. R.'s liver enzymes, in particular very high elevation of the GGT, LDH and moderate elevation of the AST. A. R.'s albumin was low, 2.5, his prothrombin time was minimally elevated, 1.1, his hemoglobin was 13.4 grams, and his platelet count was 83,000.

20. At 12:40 p.m. on December 9, 1997, respondent began a laparoscopic cholecystectomy on A. R. At the start of the procedure A. R.'s blood pressure was 130/90. The operative report indicates the intraoperative findings "included cirrhosis of the liver with a large amount of moderate collateral sac lesions in the umbilical ligament". Respondent removed A. R.'s gallbladder and "a liver biopsy was performed from the free edge of the right lobe of the liver and the site of the biopsy was then cauterized with electrocautery".

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[2] Although respondent did not have a copy of the CT scan, or report of the CT scan that had been performed on A. R. during a previous hospitalization on October 30, 1997, that CT scan showed cholelithiasis (the presence of gallstones in the gall bladder.)

[3] Neither Dr. A. O. nor respondent were aware that A. R. had a long history of abnormal liver function tests, heavy alcohol use, hypertension, depression, diabetic neuropathy, and thrombocytopenia. Also, they were unaware that A. R. had a previous ultrasonography of his abdomen performed that revealed cholelithiasis as well as a inhomogeneous liver echo consistent with diffuse liver disease, and that there was a 2 cm. nodule in the right lobe of his liver.

Although there is no mention in respondent's operative report of estimated blood loss or inspection of A. R.'s abdomen for hemostasis, respondent and the other medical personnel present, would not have "closed" on a patient who was hemorrhaging.

21. Respondent performed the liver biopsy on A. R. due to the unexpected finding of cirrhosis. Under these conditions, the performance of the liver biopsy, without A. R.'s express consent was within the standard of care. The presence of undiagnosed cirrhosis at the time of a laparotomy or laparoscopy is a strong indication to perform a biopsy, and it would be inappropriate to defer a biopsy at the time of laparoscopy due to the absence of written consent.

22. The operation ended at 1:10 p.m. and A. R. was taken to the recovery room. At approximately 1:30 p.m. A. R. became hypotensive. Blood work was done at 1:40 p.m. At 2:50 p.m. A. R. was given transfusions of O-blood, 8 units, as well a type specific on cross-match blood. A. R. was returned to the operating room with a presumptive diagnosis of hemorrhage. Postoperative bleeding is a complication that occurs with a small and unavoidable incidence no matter how careful the surgeon is. The postoperative bleeding that occurred in A. R. may have resulted from a condition known as DIC (dissemiated intravascular coagulation), a condition that occurs spontaneously in some patients. In any event, respondent acted appropriately and aggressively to address A. R.'s bleeding by giving fresh frozen plasma and by packing the liver. Respondent's actions were those expected of an experienced surgeon and reflect "absolutely the correct decision."

Respondent did not err by failing to take the time to search for coagulopathy. He did not have to search for coagulopathy. A. R. had cirrhosis, and someone with cirrhosis has coagulopathy, therefore, respondent acted appropriately by assuming coagulopathy existed and by acting accordingly by giving A. R. fresh frozen plasma.

Ultimately, through no fault of respondent's, A. R. died, probably from a myocardial infarction.

Patient A. B.:

23. A. B., a 68 year-old female, was referred to respondent by her internist on June 6, 1996 because he had found a firm, non-tender, mobile lump in A. B.'s right breast, in the upper, inner quadrant. A. B.'s internist also noted "bilateral fibrocystic disease."

A. B. first saw respondent on June 11, 1996 for a consultation. Respondent took a patient history and performed a physical examination. Respondent documented his finding a 2 cm. mass in the inner, upper quadrant of A. B.'s right breast, on the chest wall. Respondent recommended a biopsy of the mass. A. B. signed a written, informed consent for the biopsy and was scheduled for surgery on June 26, 1996.

Prior to the operation on June 26, 1996, respondent performed a history and physical examination and noted a 2 cm mass on the upper quadrant of A. B.'s right breast, on the chest wall[4]. Respondent then performed surgery on A. B. and removed the dominant mass from the upper, outer, quadrant of her right breast. The excised tissue, which measured 3 cm, was submitted for pathologic examination. The pathology report on the mass revealed fibrocystic disease. There was no evidence of malignancy, however, there was severe intraductal hyperplasia; it was pre-malignant.

24. When A. B. recovered from surgery she reported that she believed the surgery occurred in the wrong area. She expected an incision in the upper, inner quadrant of her right breast, not the upper, outer quadrant. Because she believed that respondent removed the wrong mass, A. B. refused to see him again postoperatively. Instead, she had her family physician remove the stitches and then consulted with another physician, Dr. Aragone. A. B. insisted that the wrong lump had been removed and that she could still feel the lump in the upper, inner quadrant of her right breast. A. B. showed Dr. Aragone exactly where she believed the lump to be, however, Dr. Aragone was unable to locate any dominant mass in that area. An ultrasound was performed on A. B.'s right breast and no mass or cyst was detected. Four years later A. B. had a lipoma excised from her right breast; it was not malignant. Ultimately, A. B. reported respondent to the board, stating that he had removed the wrong mass.

25. At the instant hearing A. B. and her granddaughter testified that they never saw respondent prior to his performing surgery on June 26, 1996. According to them the only medical person who saw A. B. before surgery was the nurse who started A. B.'s I.V. Accordingly, they believe respondent performed surgery without ever examining A. B. Undoubtedly A. B. and her granddaughter are mistaken. It is inconceivable that A. B. was not seen pre-op by both respondent and the anesthesiologist, even though A. B. and her granddaughter insist that neither attended to A. B. before surgery. Clearly respondent examined A. B. before surgery and determined the exact location of the dominant mass that needed to be removed. He did not make numerous incisions in a hit or miss attempt to locate a mass, he hit the mark, right on. This could not have been accomplished without a pre-op physical examination. Perhaps the granddaughter did not see the examination because it occurred after A. B. was wheeled out of the pre-op area, and perhaps A. B. can not remember due to amnesia effects of the anesthesia. In any event, the evidence indicates that respondent obtained an appropriate consent, that he performed an adequate pre-op physical examination and removed the correct mass. It is unfortunate that there was a communication breakdown, however, respondent was not aware of A. B.'s confusion until after surgery when A. B. and her granddaughter told respondent they thought he performed surgery in the wrong area. According to A. B.'s granddaughter, respondent "seemed shocked about her saying it was in

[4] According to one of the expert witnesses, Dr. Perez, it is not unusual for a mobile breast mass to shift in location depending on the patient's positioning when examined. This mass was fairly near the "outer"/"inner" quadrant demarcation line, accordingly, it is entirely possible that due to A. B.'s positioning during the different examinations the mass appeared to shift in location.

the wrong place". Respondent undoubtedly was "shocked" since he did not know that A. B. and he had somehow failed to communicate about the nature of mobile breast masses and the exact location of the mass at the time of surgery.

26. Respondent acted appropriately and professionally in his treatment of A. B. He properly document the location of the breast mass, received an appropriate informed consent for surgery on A. B.'s right breast to remove a mass, and he located and removed the mass.

Patient S. V.:

27. S. V., a 50 year-old male, was referred by his primary care physician to respondent for treatment of a necrotic 3 x 5 cm ulceration of his anterior right leg, which resulted from his having hit his shin on a trailer. S. V. consulted with respondent on September 7, 1995. S. V. completed an initial visit form and respondent reviewed S. V.'s medical history with him. S. V. was taking Trentol, however, he told respondent that he had no leg problems since he began taking the Trentol. Respondent conducted a focused physical examination. Respondent saw that the ulcer on the anterior part of S. V.'s leg, on his shin, was infected. Consequently, respondent recommended a wide excision of the ulcer and coverage with a full thickness skin graft. Respondent performed that procedure at Golden Triangle SurgiCenter on September 11, 1995. S. V. walked into the SurgiCenter for the surgery, and walked out after the surgery. There was no indication of claudication or of any acute peripheral vascular problems. This was consistent with S. V.'s internist's findings prior to referring S. V. to respondent. In late August or early September, S. V.'s internist, Dr. Felong, saw S. V. Dr. Felong noted that the pulses in S. V.'s extremities, his legs and feet, were "good". Dr. Felong referred S. V. to respondent specifically for treatment of S. V.'s non-healing, right leg contusion.

28. Respondent excised the necrotic contusion until he had viable margins so that the skin graft would meet non-infected skin at the outer borders. Accordingly, even though the infected area was approximately 3 x 5 cm, respondent had to excise a greater area, perhaps 4 x 6 or 5 x 7. Respondent then harvested 60 square cm of skin from the donor site and performed a full thickness skin graft. The area excised and the amount of skin harvested, and used, was not excessive.

29. A pathology report confirmed extensive ulceration of the infected skin, and that the margins were clear of ulceration. There were several post-op office notes. On October 24, 1995, it was noted that S. V. was doing better with local wound care. S. V. was to continue with Keflex. On November 1, 1995, S. V. saw Dr. David Newman, a plastic surgeon, and a debridement was performed. On November 6, 1995, S. V.'s wife called Dr. Newman's office and reported the S. V. was experiencing chest pain. On November 14, 1995, S. V. went to surgery and died, unexpectedly, the next day from myocardial infarction.

30. At the time respondent saw and treated S. V. he had no indication that this patient had any cardiac issues. Based upon the history given by S. V. and his referring physician, respondent had no duty to do a vascular or cardiac work-up. S. V. presented with a traumatic leg ulcer, not an ulcer based upon ischemia or cardiac ischemia. Respondent's care and treatment of S. V. was within acceptable standards of surgical care.

Evidence of Mitigation and Rehabilitation

31. Respondent's reputation in the community is that of an excellent surgeon. According to Dr. Phelps, who has known respondent since 1991, respondent is the best surgeon in the area. Dr. Felong agrees with this assessment and testified that he has so much confidence in respondent's abilities that he has sent three family members to respondent for treatment.

32. Respondent is very saddened by the fact that two patients he treated eventually died. It is hard for someone who dedicates their life to helping others to have a bad outcome, but such things happen from time to time, especially to a very busy surgeon, as respondent is.

33. Approximately two years ago, at the suggestion of a peer review committee, respondent attended and successfully completed a record keeping course at the UCSD PACE program. According to respondent his record keeping practices vastly improved as a result of the PACE program and his current record keeping practices are consistent with community standards.

Costs

34. The costs being requested for investigation total $19,462.88 and the costs being requested by Office of the Attorney General, Department of Justice, total $6,783.50, for a grand total of $26,246.38.

35. The costs requested by the Office of the Attorney General seem reasonable on their face considering the nature, extent and complexity of the case. The certifications of investigative costs are scant in their descriptions and confusing as to their meaning. For example, five separate two-page declarations, all dated February 7, 2002 were submitted. Three of the declarations bill for investigative hours spent during 1999; one bills $1,700.66 for 16.50 hours spent during 1999; another bills $438.05 for the same time frame; and the third bills $1,932.56 for the same time frame. There are five billings for investigative services during the 2000 fiscal year; one for $1,511.54; one for $4,094.89; one for $2,061.19; one for $1,786.36; and, one for $2,500.91. The same problem/confusion exists with the billings for expert review. Rather than identifying the expert(s) or providing copies of their billings, these declarations merely state the dates of review. The same dates appear on more than one of the declarations. Accordingly, without the benefit of further documentation or testimony concerning the declarations, it is impossible to determine the reasonableness of the costs from these billings. This, in conjunction with the fact that most of the allegations of the

First Amended Accusation were not proven by clear and convincing evidence, results in a reduction of the amounts sought. The Panel has reduced cost recovery to $10,000 for the charges remaining after remand from the Superior Court.

## LEGAL CONCLUSIONS

Patient W. D.:

1. It was not established by clear and convincing evidence that cause exists for discipline of respondent's certificate pursuant to Business and Professions Code ("Code") section 2234, subdivisions (b) and (c) for acts of gross negligence, and repeated negligent acts in connection with his care and treatment of patient W. D.

2. Cause exists for discipline of respondent's certificate pursuant to Code sections 2261 and 2266 because, as set forth in Findings 5, 6, 7, and 8, respondent made and signed documents/records directly related to the practice of medicine which falsely represent the existence of a state of facts, and respondent failed to maintain adequate and accurate records relating to his provision of services to W. D.

Patient W. L.:

3. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 10 through 16, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of W. L.

4. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 12 and 16, respondent failed to maintain adequate and accurate records relating to W. L.

Patient A. R.:

5. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 17 through 22, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of A. R.

6. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 19 and 20, respondent failed to maintain adequate and accurate records relating to A. R.

Patient A. B.:

7. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent, incompetent, or repeatedly negligent in his care and treatment of A. R., and his records were adequate.

Patient S. V.:

8. Cause does not exist for discipline of respondent's certificate pursuant to Code section, 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent, incompetent, or repeatedly negligent in his care and treatment of S. V., and his records were adequate.

Overall Assessment of Respondent's Documentation Concerning the Patients:

The Panel finds that respondent was sloppy and dishonest in his documentation of patient assessment, care and treatment. Presumably respondent has cured the record-keeping deficiencies by having taken the UCSD PACE records keeping course (Finding 33.)

The Panel also finds that respondent failed to adequately accept responsibility for his part in the incidents and that he has a pattern of blaming others for actions for which he is responsible under his license.

The Panel therefore must impose a level of discipline sufficient to protect the public. The Order that follows is necessary for the protection of the public, given the Panel's assessment of respondent's documentation of his patient care and treatment and his dishonesty in falsifying medical records.

Costs:

9. The Panel reduces to $10,000 the cost recovery previously awarded in this case pursuant to Business and Professions Code Section 125.3.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A 40801 and Physician Assistant Supervisor Approval No. SA 27600 issued to respondent Festus Bamidele Dada are revoked pursuant to Legal Conclusions 2, 4, and 6, separately and for all of them. However, the revocations are stayed and respondent is placed on probation for five (5) years commencing September 30, 2002, upon the following terms and conditions:

1. Within 15 days after the effective date of this decision respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

2. Within 60 days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during his one year of probation.

3. Within 30 days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored for the first two years of probation by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

If the monitor resigns or is no longer available, respondent shall, within 15 days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

4. Within 60 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a community service program in which respondent shall provide free non-medical services on a regular basis to a community or charitable facility or agency for at least 240 hours in the first year of probation.

5. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments and other orders.

6. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

7. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code Section 2021(b).

8. Respondent shall, at all times, maintain a current and renewed physician and surgeon license.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California, which lasts, or is contemplated to last, more than thirty (30) days.

9. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

10. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

11. Upon successful completion of probation, respondent's certificate and Physician Assistant Supervisor Approval number shall be fully restored.

12. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. Respondent is hereby ordered to reimburse the Division the amount of $10,000.00 within 90 days from the effective date of this decision for its investigative costs. Failure to reimburse the Division's cost of its investigation shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by respondent shall not relieve the respondent of his/her responsibility to reimburse the Division for its investigative costs.

14. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

15. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Said costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later than January 31 of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

This decision shall become effective on December 29, 2003.

IT IS SO ORDERED this 26th day of November, 2003.

Lorie Rice

LORIE G. RICE
Chairperson, Panel A
Division of Medical Quality
Medical Board of California

# EXHIBIT A

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

DATE/TIME : April 30, 2003
JUDGE : Raymond M. Cadei
REPORTER : none

DEPT. NO : 25
CLERK : Cindy Jo Miller
BAILIFF : Dave English

Festus Bamidele Dada, M.D.,,
Petitioner,

PRESENT:
Marvin Firestone

VS. Case No.: 02CS01700

Division of Medical Quality, Medical Board of California,
Department of Consumer Affairs, State of California
Respondent.
Respondent.

Mary Agnes Matyszewski

Nature of Proceedings: Court's Response to Petitioner's Request for Statement of Decision

The Court received, considered and filed Attorney Firestone's written request for Statement of Decision on April 29, 2003. The Court reviewed the Court Reporter's transcript and has determined that Petitioner's attorney *did* request a Statement of Decision. Petitioner's counsel made this request during the telephonic hearing conducted in this Court's chambers on March 7, 2003; on which date the Court took its decision under submission.

On March 14, 2003, the Court issued it's Ruling on Writ of Mandate, however, it did not request that Petitioner prepare a Statement of Decision.

The Court now hereby reaffirms its Judgment and adopts its Ruling issued on March 14, 2003, as its Statement of Decision pursuant to Code of Civil Procedure section 232(d). Each attorney may file objections to the Court's Statement of Decision.

The minute orders dated March 14, 2003 and April 23, 2003 are amended nunc pro tunc to reflect the correct date year of said minute orders as 2002.

Certificate of Service by Mailing attached.

BOOK : 25
PAGE :
DATE : April 30, 2003
CASE NO. : 02CS01700
CASE TITLE : Dada, MD vs. CA Med Brd

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SACRAMENTO

BY: Cindy Jo Miller,
Deputy Clerk

CASE NUMBER: 02CS01700
CASE TITLE: Dada, MD vs. CA Med Brd
DEPARTMENT: 25
PROCEEDINGS: Court's Ruling on Petitioner's Request for Attorneys Fees

**CERTIFICATE OF SERVICE BY MAILING**
**C.C.P. Sec. 1013a(3))**

I, the undersigned deputy clerk of the Superior Court of California, County of Sacramento, do declare under penalty of perjury that I did this date place a copy of the above entitled **Court's Response to Petitioner's Request for Statement of Decision** in envelopes addressed to each of the parties, or their counsel of record as stated below, with sufficient postage affixed thereto and deposited the same in the United States Post Office at Sacramento, California.

Marvin Firestone
Attorney at Law
730 Polhemus Rd., #200
San Mateo, CA 94402

Mary Agnes Matyszewski
Deputy Attorney General
P. O. Box 85266
San Diego, CA 92186-5266

Dated: May 1, 2003

Superior Court of California,
County of Sacramento

By: Cindy Jo Miller,
Deputy Clerk

**BOOK : 25**
**PAGE :**
**DATE : April 30, 2003**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

DATE/TIME : March 14, 2002
JUDGE : Raymond M. Cadei
REPORTER : Suzanne Burgos, #9286

DEPT. NO : 25
CLERK : Cindy Jo Miller
BAILIFF : Dave English
PRESENT:
Marvin Firestone

Festus Bamidele Dada, M.D.,,
Plaintiff,

VS. Case No.: 02CS01700

Division of Medical Quality, Medical Board of California,
Department of Consumer Affairs, State of California
Respondent.
Defendant.

Mary Agnes Matyszewski

Nature of Proceedings: Court's Ruling on Writ of Mandate
(taken under submission 3/7/03)

I. Introduction

This matter came on for hearing on March 7, 2003. The Court heard oral argument by counsel for the parties and took the matter under submission. Having considered the arguments presented at the hearing, and having read and considered the briefs and the administrative record, the Court now issues its ruling on the petition for writ of mandate.

This is a proceeding under Code of Civil Procedure section 1094.5 to review a decision of respondent Medical Board imposing discipline against petitioner Dr. Festus Dada's physician and surgeon's license. All of the relevant findings arise out of petitioner's treatment of a single patient,

BOOK : 25
PAGE :
DATE : March 14, 2002
CASE NO. : 02CS01700
CASE TITLE : Dada, MD vs. CA Med Brd

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SACRAMENTO

BY: Cindy Jo Miller,
Deputy Clerk

identified as "W.D.".[1] Petitioner was charged with negligently placing a chest tube on the wrong side of the patient when treating him for a pneumothorax. Petitioner subsequently realized that the tube had been placed on the wrong side and, just over one hour later, placed a second tube on the other side. He was also charged with preparing three medical records that failed to show that the chest tube insertions were done at separate times.

Based on these facts, the Board found that petitioner had engaged in unprofessional conduct in the form of gross negligence (Business and Professions Code section 2234(b)), repeated negligent acts (Business and Professions Code section 2234(c)) and knowingly making or signing a document directly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts (Business and Professions Code section 2261).

The Court has reviewed the relevant portions of the administrative record as they relate to petitioner's treatment and record keeping in W.D's case, and has exercised its independent judgment on the evidence as required by law. *Dresser v. Board of Medical Quality Assurance* (1982) 130

[1] The Board also made findings regarding petitioner's record keeping with regard to two other patients, but the petition does not challenge those findings and they are not discussed in this Ruling. The Board also found in favor of petitioner on charges related to his treatment of several other patients.

Cal. App. 3d 506, 510. As set forth in detail below, the Court finds that the weight of the evidence does not support the findings of gross negligence or repeated negligent acts. The weight of the evidence does, however, support the Board's findings regarding petitioner's medical records. The Court thus grants the petition for writ of mandate in part and remands the matter to respondent for redetermination of penalty in light of the Court's ruling.

## II. Analysis of Specific Board Findings

### 1. Gross Negligence

The Board found that petitioner committed an act of gross negligence by failing to review W.D.'s X-ray report before inserting the first chest tube into his left side. It is undisputed that W.D.'s pneumothorax was actually developed on the right side, but it had begun to affect the patient's left lung as well. There was radiographic evidence of mediastinal shift to the left side. The finding of gross negligence is based entirely on the testimony of the Board's expert witness, Dr. William Annan, to the effect that petitioner should have reviewed the X-ray report regarding W.D. before placing the first chest tube. (Reporter's Transcript ("R.T."), Vol. I, pages 60-61.)

The Court finds Dr. Annan's testimony to be of relatively little weight because it appears to have been based on an incorrect assumption regarding W.D.'s condition. Dr. Annan testified that W.D. was suffering from a simple pneumothorax. (R.T., Vol. I, page 144.) The Court finds, however, that the weight of the evidence established that W.D.'s condition was reasonably believed to be a tension pneumothorax. The weight of the evidence further established that a tension pneumothorax is a potentially life-threatening emergency condition requiring an immediate response from a physician.

Petitioner testified that the radiologist who informed him of W.D.'s condition told him that a tension pneumothorax had developed on the left side. (R.T., Vol. III, pages 103-104.) Petitioner's testimony on this point was unrefuted. The radiologist (the only witness who might have testified to the contrary from personal knowledge) did not testify at the administrative hearing. Moreover, petitioner's expert witness, Dr. Robert Perez, reviewed W.D.'s X-ray report and testified that it showed a tension pneumothorax in the right lung that already had begun affecting the left lung. (R.T., Vol. IV, page 22; Vol. V, page 97.) Petitioner further testified that when he performed a brief bedside examination of W.D. he found decreased breath sounds on both sides, which is consistent with a

tension pneumothorax. (R.T., Vol. III, pages 107-108.) Dr. Perez confirmed this point. (R.T., Vol. IV, page 25.) This evidence strongly indicates that it was reasonable and prudent to believe that W.D. was in fact suffering from a tension pneumothorax, and to treat it as an emergent condition. It is undisputed that a chest tube insertion is the appropriate treatment for a pneumothorax.

Dr. Annan did not recall anything in his review of the case that indicated a tension pneumothorax. He also did not recall that the X-ray report showed a mediastinal shift to the left, which would indicate a tension pneumothorax. (R.T., Vol. I, pages 144-145.) The Court thus finds that Dr. Annan's testimony was not based on a complete understanding of the actual condition of W.D. at the time of petitioner's treatment. As a result, Dr. Annan's testimony is not persuasive as to the standard of care petitioner was expected to meet in this case.

Both petitioner and Dr. Perez testified that a tension pneumothorax is an emergency that can be lethal if not treated quickly. (R.T., Vol. I, page 105; Vol. IV, page 25.) Dr. Perez testified that, under the circumstances petitioner actually faced, the standard of care permitted him to go to W.D.'s bedside immediately and treat him as he did, without first locating and reviewing the X-ray report. Additionally, Dr. Perez testified

**BOOK : 25**
**PAGE :**
**DATE : March 14, 2002**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

that petitioner acted within the standard of care by relying on the radiologist's verbal report that W.D. suffered from a tension pneumothorax on the left side. (R.T., Vol. IV, pages 25-26.)

Dr. Annan conceded that a tension pneumothorax is an emergency, but suggested that if W.D. actually had a tension pneumothorax, it was one of a less-dangerous degree because it appeared not to have been accompanied by rapidly changing vital signs. In such a case, Dr. Annan said, petitioner still could, and should, have taken the time necessary to review the X-ray report. (R.T., Vol. I, pages 144, 147-149.) The Court finds Dr. Annan's testimony on this point to be speculative and not based on a full understanding of W.D.'s condition. In fact, as noted above, the X-ray report and the presence of decreased breathing sounds on both sides indicated that the tension pneumothorax in one lung already had affected the other. W.D.'s condition thus was the kind of emergency petitioner and Dr. Perez described, requiring immediate treatment. Furthermore, it appears that the left chest tube did provide the patient some relief.

Because the weight of the evidence establishes that W.D. was likely suffering from a tension pneumothorax, Dr. Annan's testimony is not on point. There is thus no persuasive expert testimony in support of the finding that petitioner committed an act of gross negligence. The only

persuasive expert testimony stated that petitioner's treatment was within the standard of care under the circumstances. Moreover, there was no expert testimony that petitioner committed an act of ordinary negligence by inserting the tube in W.D.'s chest without first viewing the X-ray report, given the radiologist's statement that W.D. had a tension pneumothorax on his left side and the confirming evidence of bilateral decreased breathing sounds. Respondent's finding of gross negligence accordingly cannot be sustained.

2. Repeated Negligent Acts

The Court finds that the weight of the evidence does not support respondent's finding that petitioner committed repeated acts of negligence. The Court first notes that respondent's decision does not clearly identify what the repeated acts of negligence were. But since all of the negligence supposedly occurred during petitioner's treatment of W.D., and the most persuasive expert testimony established that petitioner's treatment of W.D. was in all respects within the standard of care, the evidence simply cannot support a finding of repeated negligent acts.

As discussed above, because W.D. was suffering from a tension pneumothorax, Dr. Perez persuasively testified that petitioner was not negligent in relying on the radiologist's verbal report or in proceeding to

examine W.D. and insert the chest tube without first reviewing the X-ray report. Dr. Perez also testified that petitioner's bedside examination of W.D., which confirmed decreased breath sounds on both sides, was within the standard of care. Finally, the evidence demonstrated that insertion of the tube on the left side of W.D.'s chest provided the patient with some relief. Thus, there would be no basis for a finding that petitioner was negligent by not immediately realizing that the tube had been inserted on the wrong side.

Since the evidence establishes that petitioner committed no acts of negligence in his treatment of W.D., the finding of repeated acts of negligence cannot be sustained.

3. Findings Regarding Petitioner's Medical Records

The weight of the evidence does support the finding that petitioner knowingly created medical records that falsely represented "...the existence or nonexistence of a state of facts...". (Business and Professions Code section 2261.) It is undisputed that petitioner created three records related to his treatment of W.D.: a consent form, progress notes, and an operative and consult report. A simple review of the face of these documents reveals that they describe the treatment of a bilateral pneumothorax and the insertion of both left and right chest tubes as though

everything was accomplished in a single procedure. In fact, the nurse's notes establish that the two tubes were inserted over one hour apart, in two separate procedures. Petitioner himself does not dispute the fact that two separate chest tube insertions occurred some time apart, although he attempted (unsuccessfully, in the Court's view) to minimize the time between the two procedures. Petitioner's records thus falsely represent the existence of a state of facts.

The weight of the evidence also supports the finding that petitioner knowingly created the false records. Petitioner inserted the chest tubes himself and concedes that they were placed in separate procedures some time apart. His explanation that the records as written accurately reflect what actually took place is unconvincing, as the records betray no trace of the fact that the two tubes were placed over an hour apart. Any possible suggestion that petitioner inadvertently combined the two procedures into one under the stress of the moment is negated by the fact that he dictated the third record, the operative and consult report, five days after his treatment of W.D. The Court thus finds that petitioner knowingly wrote the records in such a way as to conceal the fact that two separate insertions were done.

**BOOK : 25**
**PAGE :**
**DATE : March 14, 2002**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

III. Penalty

Petitioner also attacked respondent's penalty determination as an abuse of discretion and unduly punitive. In light of the Court's ruling on the substantive findings, it is unnecessary to address this issue. When the court's independent review of the evidence determines, as here, that some of the substantive findings are unsupported by the evidence, the penalty must be redetermined and remand to the administrative body is appropriate as a means of permitting it to exercise its discretion as to penalty on the remaining findings. Zink v. City of Sausalito (1977) 70 Cal. App. 3d 662, 666. The Court thus orders this matter remanded to respondent for redetermination of penalty in light of the Court's ruling.

IV. Conclusion

Having exercised its independent judgment on the evidence in the record, the Court finds that the weight of the evidence does not support respondent's findings of gross negligence or repeated acts of negligence in petitioner's treatment of W.D. The petition for writ of mandate is thus granted as to those findings. The weight of the evidence does support respondent's finding regarding petitioner's medical records. The petition for writ of mandate thus is denied as to that finding. The matter is ordered remanded to respondent for redetermination of penalty.

**BOOK : 25**
**PAGE :**
**DATE : March 14, 2002**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

CASE NUMBER: 02CS01700
CASE TITLE: Dada, MD vs. CA Med Brd
PROCEEDINGS: Court's Ruling on Writ of Mandate

DEPARTMENT: 25

Counsel for petitioner is directed to prepare a formal order and judgment in accordance with this Ruling, submit them to counsel for respondent for approval as to form (fax is permissible), and thereafter submit them to the Court for signature and filing.

Dated: March 14, 2003

RAYMOND M. CADEI

Honorable Raymond M. Cadei
Judge of Sacramento Superior Courts

Certificate of Service by Mailing attached.

**BOOK** : 25
**PAGE** :
**DATE** : March 14, 2002
**CASE NO.** : 02CS01700
**CASE TITLE** : Dada, MD vs. CA Med Brd

**SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

CASE NUMBER: 02CS01700
CASE TITLE: Dada, MD vs. CA Med Brd
PROCEEDINGS: Court's Ruling on Writ of Mandate

DEPARTMENT: 25

**CERTIFICATE OF SERVICE BY MAILING**
**C.C.P. Sec. 1013a(3))**

I, the undersigned deputy clerk of the Superior Court of California, County of Sacramento, do declare under penalty of perjury that I did this date place a copy of the above entitled notice in envelopes addressed to each of the parties, or their counsel of record as stated below, with sufficient postage affixed thereto and deposited the same in the United States Post Office at Sacramento, California.

Marvin Firestone
Attorney at Law
730 Polhemus Rd., #200
San Mateo, CA 94402

Mary Agnes Matyszewski
Deputy Attorney General
P. O. BOX 85266
San Diego, CA 92186-5266

Dated: March 14, 2003

Superior Court of California,
County of Sacramento

By: Cindy Jo Miller,
Deputy Clerk

**BOOK : 25**
**PAGE :**
**DATE : March 14, 2002**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

DATE/TIME : April 23, 2002
JUDGE : Raymond M. Cadei
REPORTER : Suzanne Burgos, #9286

DEPT. NO : 25
CLERK : Cindy Jo Miller
BAILIFF : Dave English
PRESENT:
Marvin Firestone

Festus Bamidele, M.D.,,
Plaintiff,

VS. Case No.: 02CS01700

Division of Medical Quality, Medical Board of California,
Department of Consumer Affairs, State of California
Respondent.
Defendant.

Mary Agnes Matyszewski

Nature of Proceedings: (1) Judgment Granting in Part and Denying in Part Petition for Writ of Mandate

(2) Court's Ruling on Petitioner's Request for Attorneys Fees

The hearing in this matter taking only approximately 1 hour or less and neither party apparently having requested a Statement of Decision in advance of the hearing a Statement of Decision is not required. See CCP 632.

Implicit in the Court's decision, served on the parties to this matter, are findings that the Respondent was neither arbitrary or capricious, nor took any action without substantial justification. Petitioner's request for attorney fees is, therefore, denied.

No further argument or hearing are necessary in this matter.

Judgment and Certificate of Service by Mailing attached.

BOOK : 25
PAGE :
DATE : April 23, 2002
CASE NO. : 02CS01700
CASE TITLE : Dada, MD vs. CA Med Brd

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SACRAMENTO

BY: Cindy Jo Miller,
Deputy Clerk

CASE NUMBER: 02CS01700
CASE TITLE: Dada, MD vs. CA Med Brd DEPARTMENT: 25
PROCEEDINGS: Court's Ruling on Petitioner's Request for Attorneys Fees

**CERTIFICATE OF SERVICE BY MAILING**
**C.C.P. Sec. 1013a(3))**

I, the undersigned deputy clerk of the Superior Court of California, County of Sacramento, do declare under penalty of perjury that I am not a party to the above-entitled action. I did this date place a copy of the above-entitled **(1) Judgment Granting in Part and Denying in Part Petition for Writ of Mandate** and **(2) Court's Order on Petitioner's Request for Attorneys Fees** in envelopes addressed to each of the parties, or their counsel of record as stated below. I affixed sufficient postage thereto, and deposited the same in the United States Post Office at Sacramento, California.

Marvin Firestone
Attorney at Law
730 Polhemus Rd., #200
San Mateo, CA 94402

Mary Agnes Matyszewski
Deputy Attorney General
P. O. BOX 85266
San Diego, CA 92186-5266

Dated: April 24, 2003

Superior Court of California,
County of Sacramento

By: Cindy Jo Miller,
Deputy Clerk

**BOOK : 25**
**PAGE :**
**DATE : April 23, 2002**
**CASE NO. : 02CS01700**
**CASE TITLE : Dada, MD vs. CA Med Brd**

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SACRAMENTO**

**BY: Cindy Jo Miller,**
**Deputy Clerk**



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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

FESTUS BAMIDELE DADA

Petitioner,

v.

DIVISION OF MEDICAL QUALITY, MEDICAL BOARD OF CALIFORNIA, DEPARTMENT OF CONSUMER AFFAIRS, STATE OF CALIFORNIA

Respondent.

Case No. 02CS01700

**JUDGMENT GRANTING IN PART AND DENYING IN PART PETITION FOR WRIT OF MANDATE**

Date: March 7, 2003
Time: 10:30 (telephonic)
Dept.: 25
Judge: Hon. Raymond Cadei

The petition for writ of mandate in the above-entitled action was heard 10:30, [telephonically] in Department 25, on March 7, 2003, by the Honorable Raymond Cadei, judge presiding. Petitioner Festus Bamidele Dada appeared by his counsel, Marvin Firestone, MD, JD; respondent appeared by its counsel Bill Lockyer, Attorney General of the State of California, by Mary Agnes Matyszewski, Deputy Attorney General. The record of the administrative proceedings, which was the subject matter of the within action, was received in evidence and read by the Court. The Court read all the pleadings on file in the action, and the matter was orally argued and submitted. Exercising its independent judgment, and consistent with its Statement of Decision issued March 14, 2003, the Court ORDERS, ADJUDGES, AND DECREES that:

1. A writ of mandate is granted in part and denied in part consistent with the Statement of Decision attached hereto.

///

2. The weight of the evidence does not support the findings of gross negligence or repeated negligent acts.

3. The weight of the evidence does support the findings of false medical records.

4. The matter is remanded to respondent for redetermination of penalty.

Dated: 4/23/03

Raymond Cadei
Judge of the Superior Court

Approved as to form:

Marvin Firestone, Esq.,
Attorney for Petitioner

Mary Agnes Matyszewski
Deputy Attorney General

Attorneys for Respondent

**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | | |
|---|---|---|
| In the Matter of the First Amended Accusation Against: | ) | |
| | ) | No. **18-1999-101312** |
| **FESTUS BAMIDELE DADA, M.D.** | ) | |
| Physician and Surgeon's Certificate No. A 40801 | ) | |
| Petitioner | ) | |

**ORDER DENYING PETITION FOR RECONSIDERATION AND REQUEST FOR STAY**

The *Petition for Reconsideration and Request for Stay of Enforcement of Order Pursuant to Government Code § 11521* filed on behalf of Festus Bamidele Dada, M.D., in the above-entitled matter, having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on September 30, 2002.

**IT IS SO ORDERED:** September 30, 2002

DAVID T. THORNTON
Chief of Enforcement
**Medical Board of California**

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

| | |
|---|---|
| In the Matter of the First Amended Accusation Against:<br><br>FESTUS BAMIDELE DADA, M.D.<br>802 Magnolia Avenue, #203<br>Corona, CA 91719<br><br>Physician's and Surgeon's Certificate No. A 40801,<br><br>Physician Assistant Supervisor Approval No. SA 27600,<br><br>Respondent. | OAH NO. L-2001050313<br><br>CASE NO. 18-1999-101312 |

DECISION AFTER NONADOPTION

This matter came on regularly for hearing before Roy W. Hewitt, Administrative Law Judge ("ALJ"), Los Angeles Office of Administrative Hearings, at San Diego, California on February 14, 15, 19, and 22, and March 19 and 20, 2002.

Deputy Attorney General Mary Agnes Matyszewski represented complainant.

Respondent, Festus B. Dada, M.D., personally appeared and was represented by Dr. Marvin Firestone, Esq.

Oral and documentary evidence was received and the matter was submitted on March 20, 2002.

The proposed decision of the administrative law judge was submitted to the Division of Medical Quality, Medical Board of California (hereafter "division") on April 8, 2002. After due consideration thereof, the division declined to adopt the proposed decision and thereafter on May 14, 2002 issued an Order of Nonadoption and subsequently issued an Order Fixing Date for Submission of Written Argument. On June 28, 2002, the division issued a Notice of Time for Oral Argument. Oral argument

was heard on August 2, 2002. The time for filing written argument in this matter having expired, written argument having been filed by both parties and such written argument, together with the entire record, including the transcript of said hearing, having been read and considered, pursuant to Government Code Section 11517, Panel A of the division hereby makes the following decision and order:

## FACTUAL FINDINGS

1. Ron Joseph filed the Accusation and the First Amended Accusation in his official capacity as the Executive Director of the Medical Board of California ("the board").

2. On April 23, 1984, the board issued Physician's and Surgeon's Certificate number A 40801, to respondent, Festus Bamidele Dada, M.D. Respondent's certificate was in full force and effect at all relevant times.

3. On August 27, 1997, the board issued Physician Assistant Supervisor Approval No. SA 27600 to respondent, Festus B. Dada. That approval was in full force and effect at all relevant times.

### Introduction

The allegations of the First Amended Accusation concern respondent's care, treatment and records concerning five separate patients. The allegations concerning each patient will be separately discussed in this Proposed Decision, under the appropriate heading.

### Patient Care

#### Patient W. D.:

4. On September 13, 1998, W. D., a 78 year-old male, was admitted to Inland Valley Regional Medical Center, Wildmar, California, with a chief complaint of generalized weakness. The following day, September 14, 1998, an x-ray revealed that W. D. had a large right pneumothorax with a slight mediastinal shift to the left side. The radiologist, Dr. Stapaciss, called respondent and discussed the case with him. At the time of the discussion respondent was performing surgery on another patient. It is unclear who was at fault, however, the radiologist either told respondent that the pneumothorax was on the left side, or respondent misunderstood the radiologist. Either way, respondent believed the pneumothorax was on W. D.'s left side. Respondent finished his surgery, went "upstairs" and quickly evaluated W. D. The evaluation, however, was grossly deficient. Instead of performing an adequate physical examination to confirm the existence and location of the pneumothorax; a "large right pneumothorax", respondent relied on the misinformation he received from

the radiologist that the pneumothorax was on the left side. (Exhibit 36, pg. 5.) Then, at approximately 12:30 p.m., respondent "proceeded to put a chest tube on the left side." (Exhibit 36, pg. 2.) After placing the tube respondent "went downstairs" and looked at the x-ray. (Exhibit 36, pg. 2) Respondent was surprised when the x-ray revealed that the pneumothorax was on the right as opposed to the left. Respondent went back upstairs and told W. D. that he had made a mistake and had to get a tube in his right side. By this time W. D. was very short of breath. (Exhibit 36, pg. 2.) At approximately 1:40 p.m. respondent placed another tube in W. D.'s right side.

5. Fluid drained from the left tube, indicating a left pleural effusion. Accordingly, the left tube helped alleviate W. D.'s problem(s) and appropriately remained inserted until 3 days later. Notwithstanding the fact that fluids drained from the left tube, respondent's chart entries and documentation fail to note any x-ray evidence, physical examination evidence or any report of the observed drainage. Consequently, respondent's documentation is substandard.

6. On September 14, 1998 at 11:30 a.m., W. D. signed an "Authorization and Consent to Surgery" reflecting his consent to "Insertion of Chest tube". Later, respondent changed the consent form to conform to W. D.'s later, verbal, consent to insertion of the right tube by adding the letter "s" to the word "tube". The consent form now reads "Insertion of Chest tubes." (Exhibit 4, AGO 2993.) Respondent's unilateral changing of the wording in the consent form, signed by W. D. and witnessed by a third party is improper. Anyone reviewing the form at a later time would be mislead into believing that W. D. initially, at 11:30 a.m., consented to the placement of both tubes, rather than just one.

7. In addition to modifying the consent form, respondent also modified his written progress note by overwriting the word "left" with the word "bilateral". The September 14, 1998 progress report now reflects that right and left chest tubes were inserted due to "bilateral pneumothorax". This progress note is incorrect and misleading. The progress note "viewed in isolation" would lead one to believe that both tubes were placed at the same time, which they were not; that both tubes were planned initially, which they were not; and that W. D. had "bilateral pneuomothorax", which he did not (he had a right pneumothrax with left pleural effusion). (Exhibit 4, AGO 3029.)

8. Five days after the surgery respondent dictated an operative and consult report that stated:

> "The patient was placed on his bed. The right and left chest were prepared with Betadine and draped in a sterile fashion....two #28 chest tubes were inserted in the fourth intercostal space and secured in place...."

Again, this note is inaccurate and misleading, especially if read along with the consent form and hand-written progress note described in Findings 6 and 7, above. Additionally, there is no written documentation in W. D.'s chart that accurately describes what happened. The only reasonable conclusion that can be drawn is that respondent was trying to conceal his mistake by making all written records of the surgery suggest that the procedures performed were contemplated at the outset and that they were done together. In truth and fact, they were done over one-hour apart.

9. Professionals, who know and work, or have worked, with respondent, all agree that respondent is an excellent surgeon. Other doctors have even sent their family members to respondent for surgery. However, it was established by clear and convincing evidence that respondent was grossly negligent and exhibited repeated negligent acts in his care and treatment of W. D. Those acts are as follows:

1) Respondent's failure to adequately evaluate W. D. before placing the left tube;

2) Respondent's acts of placing the left tube without adequate medical indication for it[1], and delay placing the right tube for over an hour after the left tube was placed (over two hours from when the surgical consent form was signed)[2]; and,

3) Respondent's creation of inaccurate and misleading records concerning W. D.'s care and treatment.

Patient W. L.[3]:

10. On May 5, 1998, patient W. L., an 86 year-old male, was admitted to Inland Valley Regional Medical Center. A consultation note made by respondent on May 5 indicates that W. L. was admitted to the hospital with fatty food intolerance, nausea and episodic abdominal pain radiating to the back.

11. A nurse prepared an "Initial Patient History Assessment" which stated that W. L. had undergone coronary artery bypass graft in 1980 and again in 1987. He had a pacemaker inserted in 1998. W. L. had blood pressure problems, cardiac

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[1] Luckily, as it turned out, the left tube was necessary to drain the left side.

[2] According to respondent's own expert, W. D.'s condition was emergent. It was life-threatening. Again, respondent, and W. D., were lucky that the delay caused by respondent's gross error(s), did not result in W. D.'s demise.

[3] At the hearing complainant moved to strike the allegations of paragraph 15, subdivisions C and D. Accordingly, the remaining allegations are that respondent was grossly negligent, repeatedly negligent and demonstrated incompetence due to his failure(s) to perform or document an adequate preoperative evaluation.

arrhythmias and prior myocardial infarction. He had past fainting spells, suffered a stroke three years before, had edema of the extremities and experienced shortness of breath on exertion. W. L. was taking numerous medications, including Hydrolozine, Imdur, Lasix, Hytrin, Cordarone, Nitro patch, Synthroid, Inabsine, and Lanoxin. Laboratory results, dated May 5, 1998, show creatinine 3.5, serum digoxin 2.7, INR 1.2, PTT 30, platelet count 99,000. An abdominal ultrasound performed the same day was interpreted as showing gallstones.

12. Respondent had treated W. L. in the past and had spoken with W. L.'s internist. Consequently, respondent, W. L.'s admitting internist, and the anesthesiologist, knew W. L. had a history of heart problems, that he had undergone two previous bypass surgeries, and that he had a pacemaker in place. Respondent was also aware of the medications W. L. was taking. Respondent's chart entries, however, fail to mention any of this. Respondent only notes that W. L. had a history of degenerative joint disease, a morphine pump implanted and chronic renal insufficiency. For the review of systems respondent simply noted "negative". The physical examination notes that the chest and lungs were clear bilaterally, and as for cardiac, respondent merely noted "S1" and "S2".

13. A progress note by another physician indicates "dehydration, renal insufficiency, history of HTN, history of TIA, thrombocytopenia, compensated congestive heart failure, admit, see orders." Immediately following this progress note, respondent writes: "surgery 1. Cholelithiasis 2. history of DJD. Plan: lap. Chole. Possible laparotomy."

14. On May 6, 1998, respondent performed a laparoscopic cholecystectomy on W. L. The operative report does not reveal any intraoperative difficulties, the operation was rather routine. Several hours after the surgery W. L. was hypotensive, he was "pale, moaning, blood pressure 78/20, rule out post op. Bleed, to surgery ASAP."

15. W. L. was returned to the operating room and underwent a laparotomy. W. L. had 600 cc's of blood in the subhepatic space and was bleeding from an arterial vessel adjacent to the cystic duct. The bleeding was controlled by electrocautery. Toward the end of the procedure W. L. suffered cardiac arrest. Attempts at resuscitation and defibrillation were unsuccessful. The autopsy suggested that W. L. died of myocardial infarction.

16. W. L.'s eventual demise was extremely unfortunate, however, respondent was not at fault. Respondent's records, however, were deficient. Respondent failed to note his awareness of W. L.'s heart disease, the existence of the pacemaker, his awareness of the medications being taken by W. L., and the nature and extent of discussions with W. L. of the considerable risks of the surgery. As previously mentioned, W. L. was referred to respondent by his internist. Respondent

spoke with the internist and the internist cleared W. L. for the surgery. Respondent did not naively care for W. L., and the death of this high-risk patient could have occurred in the best of hands.

Although respondent's preoperative evaluation of W. L. was appropriate and adequate, his documentation of the evaluation, and the factors considered, is deficient.

Patient A. R.:

17. Sometime prior to December 8, 1997, A. R. saw his internist, Dr. A. O. for the first time. Dr. A. O. took a medical history and performed a complete physical examination based on A. R.'s complaints of "continual abdominal pain" and "throwing-up" after meals. Dr. A. O. knew A. R. had diabetes, however, when asked about his drinking habits A. R. responded by stating that he only "drank on occasion." A. R. was stable, his glucose was reasonably controlled, there was "no severe disease process" at the time; his primary problem seemed to be gallstones. Dr. A. O. believed A. R. could tolerate surgery, therefore, Dr. A. O. recommended a surgical consultation with respondent for gallstone removal to prevent further complications.

18. On December 8, 1997, A. R. consulted with respondent. Respondent took a history and performed a physical examination. Respondent noted that A. R.'s chief complaint was "gallstones." A. R. was diabetic with "symptomatic gallstones"[4]. When asked about alcohol consumption A. R. claimed to only drink on occasion. A. R. was not on blood thinner.

After the consultation respondent called his internist, Dr. A. O.[5]. The two discussed A. R.'s condition and decided that a laparoscopic cholecystectomy was necessary and appropriate. Respondent asked A. R. when he wanted surgery. A. R. responded "yesterday". Respondent scheduled A. R. for surgery the next day and ordered blood tests, urinalysis, chest x-ray and EKG.

19. On December 9, 1997, A. R. was admitted to Inland Valley Regional Medical Center for a laparoscopic cholecystectomy. Respondent's written history and physical states that A. R. had recurrent abdominal pain with fatty food intolerance. Respondent documented that A. R. had asthma, diabetes, and ulcer disease.

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[4] Although respondent did not have a copy of the CT scan, or report of the CT scan that had been performed on A. R. during a previous hospitalization on October 30, 1997, that CT scan showed cholelithiasis (the presence of gallstones in the gall bladder.)

[5] Neither Dr. A. O. nor respondent were aware that A. R. had a long history of abnormal liver function tests, heavy alcohol use, hypertension, depression, diabetic neuropathy, and thrombocytopenia. Also, they were unaware that A. R. had a previous ultrasonography of his abdomen performed that revealed cholelithiasis as well as a inhomogeneous liver echo consistent with diffuse liver disease, and that there was a 2 cm. nodule in the right lobe of his liver.

Medications listed included insulin and Brontex. As a result of the physical examination respondent documented that A. R. was normal except for his abdomen, which, had "upper quadrant tenderness, no masses". Respondent failed to list A. R.'s vital signs.

Respondent met with the anesthesiologist to discuss the lab work respondent had ordered the day before. The anesthesiologist showed respondent lab results from November 2, 1997 and told respondent that these test results were acceptable to him and that there was no reason not to proceed with the surgery. Respondent agreed. The lab results, which were obtained on November 2, 1997, revealed elevation of A. R.'s liver enzymes, in particular very high elevation of the GGT, LDH and moderate elevation of the AST. A. R.'s albumin was low, 2.5, his prothrombin time was minimally elevated, 1.1, his hemoglobin was 13.4 grams, and his platelet count was 83,000.

20. At 12:40 p.m. on December 9, 1997, respondent began a laparoscopic cholecystectomy on A. R. At the start of the procedure A. R.'s blood pressure was 130/90. The operative report indicates the intraoperative findings "included cirrhosis of the liver with a large amount of moderate collateral sac lesions in the umbilical ligament". Respondent removed A. R.'s gallbladder and "a liver biopsy was performed from the free edge of the right lobe of the liver and the site of the biopsy was then cauterized with electrocautery". Although there is no mention in respondent's operative report of estimated blood loss or inspection of A. R.'s abdomen for hemostasis, respondent and the other medical personnel present, would not have "closed" on a patient who was hemorrhaging.

21. Respondent performed the liver biopsy on A. R. due to the unexpected finding of cirrhosis. Under these conditions, the performance of the liver biopsy, without A. R.'s express consent was within the standard of care. The presence of undiagnosed cirrhosis at the time of a laparotomy or laparoscopy is a strong indication to perform a biopsy, and it would be inappropriate to defer a biopsy at the time of laparoscopy due to the absence of written consent.

22. The operation ended at 1:10 p.m. and A. R. was taken to the recovery room. At approximately 1:30 p.m. A. R. became hypotensive. Blood work was done at 1:40 p.m. At 2:50 p.m. A. R. was given transfusions of O-blood, 8 units, as well a type specific on cross-match blood. A. R. was returned to the operating room with a presumptive diagnosis of hemorrhage. Postoperative bleeding is a complication that occurs with a small and unavoidable incidence no matter how careful the surgeon is. The postoperative bleeding that occurred in A. R. may have resulted from a condition known as DIC (dissemiated intravascular coagulation), a condition that occurs spontaneously in some patients. In any event, respondent acted appropriately and aggressively to address A. R.'s bleeding by giving fresh frozen plasma and by packing

the liver. Respondent's actions were those expected of an experienced surgeon and reflect "absolutely the correct decision."

Respondent did not err by failing to take the time to search for coagulopathy. He did not have to search for coagulopathy. A. R. had cirrhosis, and someone with cirrhosis has coagulopathy, therefore, respondent acted appropriately by assuming coagulopathy existed and by acting accordingly by giving A. R. fresh frozen plasma.

Ultimately, through no fault of respondent's, A. R. died, probably from a myocardial infarction.

Patient A. B.:

23. A. B., a 68 year-old female, was referred to respondent by her internist on June 6, 1996 because he had found a firm, non-tender, mobile lump in A. B.'s right breast, in the upper, inner quadrant. A. B.'s internist also noted "bilateral fibrocystic disease."

A. B. first saw respondent on June 11, 1996 for a consultation. Respondent took a patient history and performed a physical examination. Respondent documented his finding a 2 cm. mass in the inner, upper quadrant of A. B.'s right breast, on the chest wall. Respondent recommended a biopsy of the mass. A. B. signed a written, informed consent for the biopsy and was scheduled for surgery on June 26, 1996.

Prior to the operation on June 26, 1996, respondent performed a history and physical examination and noted a 2 cm mass on the upper quadrant of A. B.'s right breast, on the chest wall[6]. Respondent then performed surgery on A. B. and removed the dominant mass from the upper, outer, quadrant of her right breast. The excised tissue, which measured 3 cm, was submitted for pathologic examination. The pathology report on the mass revealed fibrocystic disease. There was no evidence of malignancy, however, there was severe intraductal hyperplasia; it was pre-malignant.

24. When A. B. recovered from surgery she reported that she believed the surgery occurred in the wrong area. She expected an incision in the upper, inner quadrant of her right breast, not the upper, outer quadrant. Because she believed that respondent removed the wrong mass, A. B. refused to see him again postoperatively. Instead, she had her family physician remove the stitches and then consulted with another physician, Dr. Aragone. A. B. insisted that the wrong lump had been

[6] According to one of the expert witnesses, Dr. Perez, it is not unusual for a mobile breast mass to shift in location depending on the patient's positioning when examined. This mass was fairly near the "outer"/"inner" quadrant demarcation line, accordingly, it is entirely possible that due to A. B.'s positioning during the different examinations the mass appeared to shift in location.

removed and that she could still feel the lump in the upper, inner quadrant of her right breast. A. B. showed Dr. Aragone exactly where she believed the lump to be, however, Dr. Aragone was unable to locate any dominant mass in that area. An ultrasound was performed on A. B.'s right breast and no mass or cyst was detected. Four years later A. B. had a lipoma excised from her right breast; it was not malignant. Ultimately, A. B. reported respondent to the board, stating that he had removed the wrong mass.

25. At the instant hearing A. B. and her granddaughter testified that they never saw respondent prior to his performing surgery on June 26, 1996. According to them the only medical person who saw A. B. before surgery was the nurse who started A. B.'s I.V. Accordingly, they believe respondent performed surgery without ever examining A. B. Undoubtedly A. B. and her granddaughter are mistaken. It is inconceivable that A. B. was not seen pre-op by both respondent and the anesthesiologist, even though A. B. and her granddaughter insist that neither attended to A. B. before surgery. Clearly respondent examined A. B. before surgery and determined the exact location of the dominant mass that needed to be removed. He did not make numerous incisions in a hit or miss attempt to locate a mass, he hit the mark, right on. This could not have been accomplished without a pre-op physical examination. Perhaps the granddaughter did not see the examination because it occurred after A. B. was wheeled out of the pre-op area, and perhaps A. B. can not remember due to amnesia effects of the anesthesia. In any event, the evidence indicates that respondent obtained an appropriate consent, that he performed an adequate pre-op physical examination and removed the correct mass. It is unfortunate that there was a communication breakdown, however, respondent was not aware of A. B.'s confusion until after surgery when A. B. and her granddaughter told respondent they thought he performed surgery in the wrong area. According to A. B.'s granddaughter, respondent "seemed shocked about her saying it was in the wrong place". Respondent undoubtedly was "shocked" since he did not know that A. B. and he had somehow failed to communicate about the nature of mobile breast masses and the exact location of the mass at the time of surgery.

26. Respondent acted appropriately and professionally in his treatment of A. B. He properly document the location of the breast mass, received an appropriate informed consent for surgery on A. B.'s right breast to remove a mass, and he located and removed the mass.

Patient S. V.:

27. S. V., a 50 year-old male, was referred by his primary care physician to respondent for treatment of a necrotic 3 x 5 cm ulceration of his anterior right leg, which resulted from his having hit his shin on a trailer. S. V. consulted with respondent on September 7, 1995. S. V. completed an initial visit form and respondent reviewed S. V.'s medical history with him. S. V. was taking Trentol,

however, he told respondent that he had no leg problems since he began taking the Trentol. Respondent conducted a focused physical examination. Respondent saw that the ulcer on the anterior part of S. V.'s leg, on his shin, was infected. Consequently, respondent recommended a wide excision of the ulcer and coverage with a full thickness skin graft. Respondent performed that procedure at Golden Triangle SurgiCenter on September 11, 1995. S. V. walked into the SurgiCenter for the surgery, and walked out after the surgery. There was no indication of claudication or of any acute peripheral vascular problems. This was consistent with S. V.'s internist's findings prior to referring S. V. to respondent. In late August or early September, S. V.'s internist, Dr. Felong, saw S. V. Dr. Felong noted that the pulses in S. V.'s extremities, his legs and feet, were "good". Dr. Felong referred S. V. to respondent specifically for treatment of S. V.'s non-healing, right leg contusion.

28. Respondent excised the necrotic contusion until he had viable margins so that the skin graft would meet non-infected skin at the outer borders. Accordingly, even though the infected area was approximately 3 x 5 cm, respondent had to excise a greater area, perhaps 4 x 6 or 5 x 7. Respondent then harvested 60 square cm of skin from the donor site and performed a full thickness skin graft. The area excised and the amount of skin harvested, and used, was not excessive.

29. A pathology report confirmed extensive ulceration of the infected skin, and that the margins were clear of ulceration. There were several post-op office notes. On October 24, 1995, it was noted that S. V. was doing better with local wound care. S. V. was to continue with Keflex. On November 1, 1995, S. V. saw Dr. David Newman, a plastic surgeon, and a debridement was performed. On November 6, 1995, S. V.'s wife called Dr. Newman's office and reported the S. V. was experiencing chest pain. On November 14, 1995, S. V. went to surgery and died, unexpectedly, the next day from myocardial infarction.

30. At the time respondent saw and treated S. V. he had no indication that this patient had any cardiac issues. Based upon the history given by S. V. and his referring physician, respondent had no duty to do a vascular or cardiac work-up. S. V. presented with a traumatic leg ulcer, not an ulcer based upon ischemia or cardiac ischemia. Respondent's care and treatment of S. V. was within acceptable standards of surgical care.

Evidence of Mitigation and Rehabilitation

31. Respondent's reputation in the community is that of an excellent surgeon. According to Dr. Phelps, who has known respondent since 1991, respondent is the best surgeon in the area. Dr. Felong agrees with this assessment and testified that he has so much confidence in respondent's abilities that he has sent three family members to respondent for treatment.

32. Respondent is very saddened by the fact that two patients he treated eventually died. It is hard for someone who dedicates their life to helping others to have a bad outcome, but such things happen from time to time, especially to a very busy surgeon, as respondent is.

33. Approximately two years ago, at the suggestion of a peer review committee, respondent attended and successfully completed a record keeping course at the UCSD PACE program. According to respondent his record keeping practices vastly improved as a result of the PACE program and his current record keeping practices are consistent with community standards.

Costs

34. The costs being requested for investigation total $19,462.88 and the costs being requested by Office of the Attorney General, Department of Justice, total $6,783.50, for a grand total of $26,246.38.

35. The costs requested by the Office of the Attorney General seem reasonable on their face considering the nature, extent and complexity of the case. The certifications of investigative costs are scant in their descriptions and confusing as to their meaning. The ALJ can not tell by these certifications whether there is some overlap or duplication of costs. For example, five separate two-page declarations, all dated February 7, 2002 were submitted. Three of the declarations bill for investigative hours spent during 1999; one bills $1,700.66 for 16.50 hours spent during 1999; another bills $438.05 for the same time frame; and the third bills $1,932.56 for the same time frame. There are five billings for investigative services during the 2000 fiscal year; one for $1,511.54; one for $4,094.89; one for $2,061.19; one for $1,786.36; and, one for $2,500.91. The same problem/confusion exists with the billings for expert review. Rather than identifying the expert(s) or providing copies of their billings, these declarations merely state the dates of review. The same dates appear on more than one of the declarations. Accordingly, without the benefit of further documentation or testimony concerning the declarations, it is impossible to determine the reasonableness of the costs from these billings. This, in conjunction with the fact that most of the allegations of the First Amended Accusation were not proven by clear and convincing evidence, results in a reduction of the amounts sought. Of the $26,246.38 being requested, $15,000.00 represents the reasonable costs of the investigation and enforcement of the instant case against respondent, recoverable by the board pursuant to Code section 125.3

## LEGAL CONCLUSIONS

Patient W. D.:

1. Causes exist for discipline of respondent's certificate pursuant to Business and Professions Code ("Code") section 2234, subdivisions (b) and (c) because, as set forth in Findings 4, 5, 6, 7, 8, and 9, respondent committed acts of gross negligence, and repeated negligent acts in connection with his care and treatment of patient W. D.

2. Cause exists for discipline of respondent's certificate pursuant to Code sections 2261 and 2266 because, as set forth in Findings 5, 6, 7, and 8, respondent made and signed documents/records directly related to the practice of medicine which falsely represent the existence of a state of facts, and respondent failed to maintain adequate and accurate records relating to his provision of services to W. D.

Patient W. L.:

3. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 10 through 16, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of W. L.

4. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 12 and 16, respondent failed to maintain adequate and accurate records relating to W. L.

Patient A. R.:

5. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 17 through 22, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of A. R.

6. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 19 and 20, respondent failed to maintain adequate and accurate records relating to A. R.

Patient A. B.:

7. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent,

incompetent, or repeatedly negligent in his care and treatment of A. R., and his records were adequate.

Patient S. V.:

8. Cause does not exist for discipline of respondent's certificate pursuant to Code section, 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent, incompetent, or repeatedly negligent in his care and treatment of S. V., and his records were adequate.

Overall Assessment of Respondent's Care and Treatment of the Patients and His Documentation Concerning the Patients:

The only incident that involved gross negligence, and repeated negligent acts concerned patient W. D. In that case there was no evidence that respondent lacked the appropriate knowledge, skill or training to evaluate and treat W. D. Respondent accepted erroneous information he gleaned from a conversation with the radiologist concerning the location of the pneumothorax. Respondent should have taken the time to corroborate those findings before implanting the first chest tube. Then, respondent tried to conceal the mistake by making misleading chart entries.

The Panel finds that respondent was sloppy in his procedures and was sloppy and dishonest in his documentation of patient assessment, care and treatment. Presumably respondent has cured the record-keeping deficiencies by having taken the UCSD PACE records keeping course (Finding 33.)

The Panel also finds that respondent failed to adequately accept responsibility for his part in the incidents and that he has a pattern of blaming others for actions for which he is responsible under his license.

The Panel therefore must impose a level of discipline sufficient to protect the public. The Order that follows is necessary for the protection of the public, given the Panel's assessment of respondent's care and treatment of his patients and his documentation of that care and treatment.

Costs:

9. $15,000.00 represents the reasonable costs of the investigation and enforcement of the instant case against respondent, recoverable by the board pursuant to Code section 125.3

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A 40801 and Physician Assistant Supervisor Approval No. SA 27600 issued to respondent Festus Bamidele Dada are revoked pursuant to Legal Conclusions 1, 2, 4, and 6, separately and for all of them. However, the revocations are stayed and respondent is placed on probation for five (5) years upon the following terms and conditions:

1. Within 15 days after the effective date of this decision respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

2. Within 60 days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during his one year of probation.

3. Within 90 days of the effective date of this decision, respondent shall submit to the Division or its designee for prior approval, a clinical training or educational program such as the Physician Assessment and Clinical Education Program (PACE) offered by the University of California – San Diego School of Medicine or equivalent program as approved by the Division or its designee.

Respondent shall successfully complete the training program and shall comply with the clinical training program recommendation(s) and may be required to pass an examination administered by the Division or its designee related to the program's

contents. The respondent shall pay the costs of all clinical training or educational programs.

4. Within 30 days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored for the first two years of probation by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

If the monitor resigns or is no longer available, respondent shall, within 15 days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

5. Within 60 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a community service program in which respondent shall provide free non-medical services on a regular basis to a community or charitable facility or agency for at least 240 hours in the first year of probation.

6. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments and other orders.

7. Respondent shall submit quarterly declarations under penalty of perjury on forms provide by the Division, stating whether there has been compliance with all the conditions of probation.

8. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code Section 2021(b).

9. Respondent shall, at all times, maintain a current and renewed physician and surgeon license.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California, which lasts, or is contemplated to last, more than thirty (30) days.

10. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

11. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

12. Upon successful completion of probation, respondent's certificate and Physician Assistant Supervisor Approval number shall be fully restored.

13. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. Respondent is hereby ordered to reimburse the Division the amount of $15,000.00 within 90 days from the effective date of this decision for its investigative costs. Failure to reimburse the Division's cost of its investigation shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of

bankruptcy by respondent shall not relieve the respondent of his/her responsibility to reimburse the Division for its investigative costs.

15. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

16. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Said costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later that January 31 of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

This decision shall become effective on September 30, 2002.

IT IS SO ORDERED this 30th day of August, 2002.

LORIE G. RICE
Chairperson, Panel A
Division of Medical Quality
Medical Board of California

**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against: | ) | |
| **FESTUS BAMIDELE DADA, M.D.** | ) | Case No.: 18-1999-101312 |
| Physician's & Surgeon's Certificate No.: A 40801 | ) | OAH No.: L-2001050313 |
| Respondent | ) | |

## NOTICE OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** The Medical Board of California, Division of Medical Quality, will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including in particular, argument directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact the Transcript Clerk, Office of Administrative Hearings, 320 West Fourth Street, 6th Floor, Suite 630, Los Angeles, CA 90013. The telephone number is (213) 576-7200.

In addition to written argument, oral argument will be scheduled if any party files with the Division within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Division will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Division. The mailing address of the Division is as follows:

Division of Medical Quality
MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2639

Dated: May 14, 2002

Valerie Moore
Enforcement Legal Unit

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the First Amended Accusation Against:<br><br>FESTUS BAMIDELE DADA, M.D.<br>802 Magnolia Avenue, #203<br>Corona, CA 91719<br><br>Physician's and Surgeon's Certificate No. A 40801,<br><br>Physician Assistant Supervisor Approval No. SA 27600,<br><br>Respondent. | OAH NO. L-2001050313<br><br>CASE NO. 18-1999-101312 |

## PROPOSED DECISION

This matter came on regularly for hearing before Roy W. Hewitt, Administrative Law Judge ("ALJ"), Los Angeles Office of Administrative Hearings, at San Diego, California on February 14, 15, 19, and 22, and March 19 and 20, 2002.

Deputy Attorney General Mary Agnes Matyszewski represented complainant.

Respondent, Festus B. Dada, M.D., personally appeared and was represented by Dr. Marvin Firestone, Esq.

Oral and documentary evidence was received and the matter was submitted on March 20, 2002.

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## FACTUAL FINDINGS

The ALJ makes the following Factual Findings:

1. Ron Joseph filed the Accusation and the First Amended Accusation in his official capacity as the Executive Director of the Medical Board of California ("the board").

2. On April 23, 1984, the board issued Physician's and Surgeon's Certificate number A 40801, to respondent, Festus Bamidele Dada, M.D. Respondent's certificate was in full force and effect at all relevant times.

3. On August 27, 1997, the board issued Physician Assistant Supervisor Approval No. SA 27600 to respondent, Festus B. Dada. That Approval was in full force and effect at all relevant times.

### Introduction

The allegations of the First Amended Accusation concern respondent's care, treatment and records concerning five separate patients. The allegations concerning each patient will be separately discussed in this Proposed Decision, under the appropriate heading.

### Patient Care

#### Patient W. D.:

4. On September 13, 1998, W. D., a 78 year-old male, was admitted to Inland Valley Regional Medical Center, Wildmar, California, with a chief complaint of generalized weakness. The following day, September 14, 1998, an x-ray revealed that W. D. had a large right pneumothorax with a slight mediastinal shift to the left side. The radiologist, Dr. Stapaciss, called respondent and discussed the case with him. At the time of the discussion respondent was performing surgery on another patient. It is unclear who was at fault, however, the radiologist either told respondent that the pneumothorax was on the left side, or respondent misunderstood the radiologist. Either way, respondent believed the pneumothorax was on W. D.'s left side. Respondent finished his surgery, went "upstairs" and quickly evaluated W. D. The evaluation, however, was grossly deficient. Instead of performing an adequate physical examination to confirm the existence and location of the pneumothorax; a "large right pneumothorax", respondent relied on the misinformation he received from the radiologist that the pneumothorax was on the left side. (Exhibit 36, pg. 5.) Then, at approximately 12:30 p.m., respondent "proceeded to put a chest tube on the left side." (Exhibit 36, pg. 2.) After placing the tube respondent "went downstairs" and

looked at the x-ray. (Exhibit 36, pg. 2) Respondent was surprised when the x-ray revealed that the pneumothorax was on the right as opposed to the left. Respondent went back upstairs and told W. D. that he had made a mistake and had to get a tube in his right side. By this time W. D. was very short of breath. (Exhibit 36, pg. 2.) At approximately 1:40 p.m. respondent placed another tube in W. D.'s right side.

5. Fluid drained from the left tube, indicating a left pleural effusion. Accordingly, the left tube helped alleviate W. D.'s problem(s) and appropriately remained inserted until 3 days later. Notwithstanding the fact that fluids drained from the left tube, respondent's chart entries and documentation fail to note any x-ray evidence, physical examination evidence or any report of the observed drainage. Consequently, respondent's documentation is substandard.

6. On September 14, 1998 at 11:30 a.m., W. D. signed an "Authorization and Consent to Surgery" reflecting his consent to "Insertion of Chest tube". Later, respondent changed the consent form to conform to W. D.'s later, verbal, consent to insertion of the right tube by adding the letter "s" to the word "tube". The consent form now reads "Insertion of Chest tubes." (Exhibit 4, AGO 2993.) Respondent's unilateral changing of the wording in the consent form, signed by W. D. and witnessed by a third party is improper. Anyone reviewing the form at a later time would be mislead into believing that W. D. initially, at 11:30 a.m., consented to the placement of both tubes, rather than just one.

7. In addition to modifying the consent form, respondent also modified his written progress note by overwriting the word "left" with the word "bilateral". The September 14, 1998 progress report now reflects that right and left chest tubes were inserted due to "bilateral pneumothorax". This progress note is incorrect and misleading. The progress note "viewed in isolation" would lead one to believe that both tubes were placed at the same time, which they were not; that both tubes were planned initially, which they were not; and that W. D. had "bilateral pneuomothorax", which he did not (he had a right pneumothrax with left pleural effusion). (Exhibit 4, AGO 3029.)

8. Five days after the surgery respondent dictated an operative and consult report that stated:

> "The patient was placed on his bed. The right and left chest were prepared with Betadine and draped in a sterile fashion....two #28 chest tubes were inserted in the fourth intercostal space and secured in place...."

Again, this note is inaccurate and misleading, especially if read along with the consent form and hand-written progress note described in Findings 6 and 7,

above. Additionally, there is no written documentation in W. D.'s chart that accurately describes what happened. The only reasonable conclusion that can be drawn is that respondent was trying to conceal his mistake by making all written records of the surgery suggest that the procedures performed were contemplated at the outset and that they were done together. In truth and fact, they were done over one-hour apart.

9. The ALJ does not believe that respondent is incompetent, in fact other professionals, who know and work, or have worked, with respondent, all agree that respondent is an excellent surgeon. Other doctors have even sent their family members to respondent for surgery. However, the ALJ does believe clearly and convincingly, that respondent was grossly negligent and exhibited repeated negligent acts in his care and treatment of W. D. Those acts are as follows:

1) Respondent's failure to adequately evaluate W. D. before placing the left tube;

2) Respondent's acts of placing the left tube without adequate medical indication for it[1], and delay placing the right tube for over an hour after the left tube was placed (over two hours from when the surgical consent form was signed)[2]; and,

3) Respondent's creation of inaccurate and misleading records concerning W. D.'s care and treatment.

Patient W. L.[3]:

10. On May 5, 1998, patient W. L., an 86 year-old male, was admitted to Inland Valley Regional Medical Center. A consultation note made by respondent on May 5 indicates that W. L. was admitted to the hospital with fatty food intolerance, nausea and episodic abdominal pain radiating to the back.

11. A nurse prepared an "Initial Patient History Assessment" which stated that W. L. had undergone coronary artery bypass graft in 1980 and again in 1987. He had a pacemaker inserted in 1998. W. L. had blood pressure problems, cardiac

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[1] Luckily, as it turned out, the left tube was necessary to drain the left side.

[2] According to respondent's own expert, W. D.'s condition was emergent. It was life-threatening. Again, respondent, and W. D., were lucky that the delay caused by respondent's gross error(s), did not result in W. D.'s demise.

[3] At the hearing complainant moved to strike the allegations of paragraph 15, subdivisions C and D. Accordingly, the remaining allegations are that respondent was grossly negligent, repeatedly negligent and demonstrated incompetence due to his failure(s) to perform or document an adequate preoperative evaluation.

arrhythmias and prior myocardial infarction. He had past fainting spells, suffered a stroke three years before, had edema of the extremities and experienced shortness of breath on exertion. W. L. was taking numerous medications, including Hydrolozine, Imdur, Lasix, Hytrin, Cordarone, Nitro patch, Synthroid, Inabsine, and Lanoxin. Laboratory results, dated May 5, 1998, show creatinine 3.5, serum digoxin 2.7, INR 1.2, PTT 30, platelet count 99,000. An abdominal ultrasound performed the same day was interpreted as showing gallstones.

12. Respondent had treated W. L. in the past and had spoken with W. L.'s internist. Consequently, respondent, W. L.'s admitting internist, and the anesthesiologist, knew W. L. had a history of heart problems, that he had undergone two previous bypass surgeries, and that he had a pacemaker in place. Respondent was also aware of the medications W. L. was taking. Respondent's chart entries, however, fail to mention any of this. Respondent only notes that W. L. had a history of degenerative joint disease, a morphine pump implanted and chronic renal insufficiency. For the review of systems respondent simply noted "negative". The physical examination notes that the chest and lungs were clear bilaterally, and as for cardiac, respondent merely noted "S1" and "S2".

13. A progress note by another physician indicates "dehydration, renal insufficiency, history of HTN, history of TIA, thrombocytopenia, compensated congestive heart failure, admit, see orders." Immediately following this progress note, respondent writes: "surgery 1. Cholelithiasis 2. history of DJD. Plan: lap. Chole. Possible laparotomy."

14. On May 6, 1998, respondent performed a laparoscopic cholecystectomy on W. L. The operative report does not reveal any intraoperative difficulties, the operation was rather routine. Several hours after the surgery W. L. was hypotensive, he was "pale, moaning, blood pressure 78/20, rule out post op. Bleed, to surgery ASAP."

15. W. L. was returned to the operating room and underwent a laparotomy. W. L. had 600 cc's of blood in the subhepatic space and was bleeding from an arterial vessel adjacent to the cystic duct. The bleeding was controlled by electrocautery. Toward the end of the procedure W. L. suffered cardiac arrest. Attempts at resuscitation and defibrillation were unsuccessful. The autopsy suggested that W. L. died of myocardial infarction.

16. W. L.'s eventual demise was extremely unfortunate, however, respondent was not at fault. Respondent's records, however, were deficient. Respondent failed to note his awareness of W. L.'s heart disease, the existence of the pacemaker, his awareness of the medications being taken by W. L., and the nature and extent of discussions with W. L. of the considerable risks of the surgery. As

previously mentioned, W. L. was referred to respondent by his internist. Respondent spoke with the internist and the internist cleared W. L. for the surgery. Respondent did not naively care for W. L., and the death of this high-risk patient could have occurred in the best of hands.

Although respondent's preoperative evaluation of W. L. was appropriate and adequate, his documentation of the evaluation, and the factors considered, is deficient.

Patient A. R.:

17. Sometime prior to December 8, 1997, A. R. saw his internist, Dr. A. O. for the first time. Dr. A. O. took a medical history and performed a complete physical examination based on A. R.'s complaints of "continual abdominal pain" and "throwing-up" after meals. Dr. A. O. knew A. R. had diabetes, however, when asked about his drinking habits A. R. responded by stating that he only "drank on occasion." A. R. was stable, his glucose was reasonably controlled, there was "no severe disease process" at the time; his primary problem seemed to be gallstones. Dr. A. O. believed A. R. could tolerate surgery, therefore, Dr. A. O. recommended a surgical consultation with respondent for gallstone removal to prevent further complications.

18. On December 8, 1997, A. R. consulted with respondent. Respondent took a history and performed a physical examination. Respondent noted that A. R.'s chief complaint was "gallstones." A. R. was diabetic with "symptomatic gallstones"[4]. When asked about alcohol consumption A. R. claimed to only drink on occasion. A. R. was not on blood thinner.

After the consultation respondent called his internist, Dr. A. O.[5]. The two discussed A. R.'s condition and decided that a laparoscopic cholecystectomy was necessary and appropriate. Respondent asked A. R. when he wanted surgery. A. R. responded "yesterday". Respondent scheduled A. R. for surgery the next day and ordered blood tests, urinalysis, chest x-ray and EKG.

19. On December 9, 1997, A. R. was admitted to Inland Valley Regional Medical Center for a laparoscopic cholecystectomy. Respondent's written history and

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[4] Although respondent did not have a copy of the CT scan, or report of the CT scan that had been performed on A. R. during a previous hospitalization on October 30, 1997, that CT scan showed cholelithiasis (the presence of gallstones in the gall bladder.)

[5] Neither Dr. A. O. nor respondent were aware that A. R. had a long history of abnormal liver function tests, heavy alcohol use, hypertension, depression, diabetic neuropathy, and thrombocytopenia. Also, they were unaware that A. R. had a previous ultrasonography of his abdomen performed that revealed cholelithiasis as well as a inhomogeneous liver echo consistent with diffuse liver disease, and that there was a 2 cm. nodule in the right lobe of his liver.

physical states that A. R. had recurrent abdominal pain with fatty food intolerance. Respondent documented that A. R. had asthma, diabetes, and ulcer disease. Medications listed included insulin and Brontex. As a result of the physical examination respondent documented that A. R. was normal except for his abdomen, which, had "upper quadrant tenderness, no masses". Respondent failed to list A. R.'s vital signs.

Respondent met with the anesthesiologist to discuss the lab work respondent had ordered the day before. The anesthesiologist showed respondent lab results from November 2, 1997 and told respondent that these test results were acceptable to him and that there was no reason not to proceed with the surgery. Respondent agreed. The lab results, which were obtained on November 2, 1997, revealed elevation of A. R.'s liver enzymes, in particular very high elevation of the GGT, LDH and moderate elevation of the AST. A. R.'s albumin was low, 2.5, his prothrombin time was minimally elevated, 1.1, his hemoglobin was 13.4 grams, and his platelet count was 83,000.

20. At 12:40 p.m. on December 9, 1997, respondent began a laparoscopic cholecystectomy on A. R. At the start of the procedure A. R.'s blood pressure was 130/90. The operative report indicates the intraoperative findings "included cirrhosis of the liver with a large amount of moderate collateral sac lesions in the umbilical ligament". Respondent removed A. R.'s gallbladder and "a liver biopsy was performed from the free edge of the right lobe of the liver and the site of the biopsy was then cauterized with electrocautery". Although there is no mention in respondent's operative report of estimated blood loss or inspection of A. R.'s abdomen for hemostasis, respondent and the other medical personnel present, would not have "closed" on a patient who was hemorrhaging.

21. Respondent performed the liver biopsy on A. R. due to the unexpected finding of cirrhosis. Under these conditions, the performance of the liver biopsy, without A. R.'s express consent was within the standard of care. The presence of undiagnosed cirrhosis at the time of a laparotomy or laparoscopy is a strong indication to perform a biopsy, and it would be inappropriate to defer a biopsy at the time of laparoscopy due to the absence of written consent.

22. The operation ended at 1:10 p.m. and A. R. was taken to the recovery room. At approximately 1:30 p.m. A. R. became hypotensive. Blood work was done at 1:40 p.m. At 2:50 p.m. A. R. was given transfusions of O-blood, 8 units, as well a type specific on cross-match blood. A. R. was returned to the operating room with a presumptive diagnosis of hemorrhage. Postoperative bleeding is a complication that occurs with a small and unavoidable incidence no matter how careful the surgeon is. The postoperative bleeding that occurred in A. R. may have resulted from a condition known as DIC (dissemiated intravascular coagulation), a condition that occurs

spontaneously in some patients. In any event, respondent acted appropriately and aggressively to address A. R.'s bleeding by giving fresh frozen plasma and by packing the liver. Respondent's actions were those expected of an experienced surgeon and reflect "absolutely the correct decision."

Respondent did not err by failing to take the time to search for coagulopathy. He did not have to search for coagulopathy. A. R. had cirrhosis, and someone with cirrhosis has coagulopathy, therefore, respondent acted appropriately by assuming coagulopathy existed and by acting accordingly by giving A. R. fresh frozen plasma.

Ultimately, through no fault of respondent's, A. R. died, probably from a myocardial infarction.

Patient A. B.:

23. A. B., a 68 year-old female, was referred to respondent by her internist on June 6, 1996 because he had found a firm, non-tender, mobile lump in A. B.'s right breast, in the upper, inner quadrant. A. B.'s internist also noted "bilateral fibrocystic disease."

A. B. first saw respondent on June 11, 1996 for a consultation. Respondent took a patient history and performed a physical examination. Respondent documented his finding a 2 cm. mass in the inner, upper quadrant of A. B.'s right breast, on the chest wall. Respondent recommended a biopsy of the mass. A. B. signed a written, informed consent for the biopsy and was scheduled for surgery on June 26, 1996.

Prior to the operation on June 26, 1996, respondent performed a history and physical examination and noted a 2 cm mass on the upper quadrant of A. B.'s right breast, on the chest wall[6]. Respondent then performed surgery on A. B. and removed the dominant mass from the upper, outer, quadrant of her right breast. The excised tissue, which measured 3 cm, was submitted for pathologic examination. The pathology report on the mass revealed fibrocystic disease. There was no evidence of malignancy, however, there was severe intraductal hyperplasia; it was pre-malignant.

24. When A. B. recovered from surgery she reported that she believed the surgery occurred in the wrong area. She expected an incision in the upper, inner quadrant of her right breast, not the upper, outer quadrant. Because she believed that

[6] According to one of the expert witnesses, Dr. Perez, it is not unusual for a mobile breast mass to shift in location depending on the patient's positioning when examined. This mass was fairly near the "outer"/"inner" quadrant demarcation line, accordingly, it is entirely possible that due to A. B.'s positioning during the different examinations the mass appeared to shift in location.

respondent removed the wrong mass, A. B. refused to see him again postoperatively. Instead, she had her family physician remove the stitches and then consulted with another physician, Dr. Aragone. A. B. insisted that the wrong lump had been removed and that she could still feel the lump in the upper, inner quadrant of her right breast. A. B. showed Dr. Aragone exactly where she believed the lump to be, however, Dr. Aragone was unable to locate any dominant mass in that area. An ultrasound was performed on A. B.'s right breast and no mass or cyst was detected. Four years later A. B. had a lipoma excised from her right breast; it was not malignant. Ultimately, A. B. reported respondent to the board, stating that he had removed the wrong mass.

25. At the instant hearing A. B. and her granddaughter testified that they never saw respondent prior to his performing surgery on June 26, 1996. According to them the only medical person who saw A. B. before surgery was the nurse who started A. B.'s I.V. Accordingly, they believe respondent performed surgery without ever examining A. B. Undoubtedly A. B. and her granddaughter are mistaken. It is inconceivable that A. B. was not seen pre-op by both respondent and the anesthesiologist, even though A. B. and her granddaughter insist that neither attended to A. B. before surgery. Clearly respondent examined A. B. before surgery and determined the exact location of the dominant mass that needed to be removed. He did not make numerous incisions in a hit or miss attempt to locate a mass, he hit the mark, right on. This could not have been accomplished without a pre-op physical examination. Perhaps the granddaughter did not see the examination because it occurred after A. B. was wheeled out of the pre-op area, and perhaps A. B. can not remember due to amnesia effects of the anesthesia. In any event, the evidence indicates that respondent obtained an appropriate consent, that he performed an adequate pre-op physical examination and removed the correct mass. It is unfortunate that there was a communication breakdown, however, respondent was not aware of A. B.'s confusion until after surgery when A. B. and her granddaughter told respondent they thought he performed surgery in the wrong area. According to A. B.'s granddaughter, respondent "seemed shocked about her saying it was in the wrong place". Respondent undoubtedly was "shocked" since he did not know that A. B. and he had somehow failed to communicate about the nature of mobile breast masses and the exact location of the mass at the time of surgery.

26. Respondent acted appropriately and professionally in his treatment of A. B. He properly document the location of the breast mass, received an appropriate informed consent for surgery on A. B.'s right breast to remove a mass, and he located and removed the mass.

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Patient S. V.:

27. S. V., a 50 year-old male, was referred by his primary care physician to respondent for treatment of a necrotic 3 x 5 cm ulceration of his anterior right leg, which resulted from his having hit his shin on a trailer. S. V. consulted with respondent on September 7, 1995. S. V. completed an initial visit form and respondent reviewed S. V.'s medical history with him. S. V. was taking Trentol, however, he told respondent that he had no leg problems since he began taking the Trentol. Respondent conducted a focused physical examination. Respondent saw that the ulcer on the anterior part of S. V.'s leg, on his shin, was infected. Consequently, respondent recommended a wide excision of the ulcer and coverage with a full thickness skin graft. Respondent performed that procedure at Golden Triangle SurgiCenter on September 11, 1995. S. V. walked into the SurgiCenter for the surgery, and walked out after the surgery. There was no indication of claudication or of any acute peripheral vascular problems. This was consistent with S. V.'s internist's findings prior to referring S. V. to respondent. In late August or early September, S. V.'s internist, Dr. Felong, saw S. V. Dr. Felong noted that the pulses in S. V.'s extremities, his legs and feet, were "good". Dr. Felong referred S. V. to respondent specifically for treatment of S. V.'s non-healing, right leg contusion.

28. Respondent excised the necrotic contusion until he had viable margins so that the skin graft would meet non-infected skin at the outer borders. Accordingly, even though the infected area was approximately 3 x 5 cm, respondent had to excise a greater area, perhaps 4 x 6 or 5 x 7. Respondent then harvested 60 square cm of skin from the donor site and performed a full thickness skin graft. The area excised and the amount of skin harvested, and used, was not excessive.

29. A pathology report confirmed extensive ulceration of the infected skin, and that the margins were clear of ulceration. There were several post-op office notes. On October 24, 1995, it was noted that S. V. was doing better with local wound care. S. V. was to continue with Keflex. On November 1, 1995, S. V. saw Dr. David Newman, a plastic surgeon, and a debridement was performed. On November 6, 1995, S. V.'s wife called Dr. Newman's office and reported the S. V. was experiencing chest pain. On November 14, 1995, S. V. went to surgery and died, unexpectedly, the next day from myocardial infarction.

30. At the time respondent saw and treated S. V. he had no indication that this patient had any cardiac issues. Based upon the history given by S. V. and his referring physician, respondent had no duty to do a vascular or cardiac work-up. S. V. presented with a traumatic leg ulcer, not an ulcer based upon ischemia or cardiac ischemia. Respondent's care and treatment of S. V. was within acceptable standards of surgical care.

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## Evidence of Mitigation and Rehabilitation

31. Respondent's reputation in the community is that of an excellent surgeon. According to Dr. Phelps, who has known respondent since 1991, respondent is the best surgeon in the area. Dr. Felong agrees with this assessment and testified that he has so much confidence in respondent's abilities that he has sent three family members to respondent for treatment.

32. Respondent is very saddened by the fact that two patients he treated eventually died. It is hard for someone who dedicates their life to helping others to have a bad outcome, but such things happen from time to time, especially to a very busy surgeon, as respondent is.

33. Approximately two years ago, at the suggestion of a peer review committee, respondent attended and successfully completed a record keeping course at the UCSD PACE program. According to respondent his record keeping practices vastly improved as a result of the PACE program and his current record keeping practices are consistent with community standards.

## Costs

34. The costs being requested by the Division of Investigation total $19,462.88 and the costs being requested by Office of the Attorney General, Department of Justice, total $6,783.50, for a grand total of $26,246.38.

35. The cost requested by the Office of the Attorney General seem reasonable on their face considering the nature, extent and complexity of the case. The Division of Investigation's certifications of costs are scant in their descriptions and confusing as to their meaning. The ALJ can not tell by these certifications whether there is some overlap or duplication of costs. For example, the Division submitted five separate two-page declarations, all dated February 7, 2002. Three of the declarations bill for investigative hours spent during 1999; one bills $1,700.66 for 16.50 hours spent during 1999; another bills $438.05 for the same time frame; and the third bills $1,932.56 for the same time frame. There are five billings for investigative services during the 2000 fiscal year; one for $1,511.54; one for $4,094.89; one for $2,061.19; one for $1,786.36; and, one for $2,500.91. The same problem/confusion exists with the billings for expert review. Rather than identifying the expert(s) or providing copies of their billings, these declarations merely state the dates of review. The same dates appear on more than one of the declarations. Accordingly, without the benefit of further documentation or testimony concerning the declarations, it is impossible to determine the reasonableness of the costs from these billings. This, in conjunction with the fact that most of the allegations of the First Amended Accusation were not proven by clear and convincing evidence, results in a reduction of the

amounts sought. Of the $26,246.38 being requested, $15,000.00 represents the reasonable costs of the investigation and enforcement of the instant case against respondent, recoverable by the board pursuant to Code section 125.3

## LEGAL CONCLUSIONS

The Administrative Law Judge makes the following Legal Conclusions:

Patient W. D.:

1. Causes exist for discipline of respondent's certificate pursuant to Business and Professions Code ("Code") section 2234, subdivisions (b) and (c) because, as set forth in Findings 4, 5, 6, 7, 8, and 9, respondent committed acts of Gross Negligence, and Repeated Negligent Acts in connection with his care and treatment of patient W. D.

2. Cause exists for discipline of respondent's certificate pursuant to Code sections 2261 and 2266 because, as set forth in Findings 5, 6, 7, and 8, respondent made and signed documents/records directly related to the practice of medicine which falsely represent the existence of a state of facts, and respondent failed to maintain adequate and accurate records relating to his provision of services to W. D.

Patient W. L.:

3. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 10 through 16, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of W. L.

4. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 12 and 16, respondent failed to maintain adequate and accurate records relating to W. L.

Patient A. R.:

5. Cause does not exist for discipline of respondent's certificate pursuant to Code section 2234, subdivisions (b), (c), or (d) because, as set forth in Findings 17 through 22, respondent was not grossly negligent, incompetent, nor was he repeatedly negligent in his care and treatment of A. R.

6. Cause exists for discipline of respondent's certificate pursuant to Code section 2266 because, as set forth in Findings 19 and 20, respondent failed to maintain adequate and accurate records relating to A. R.

Patient A. B.:

7. Cause does not exist for discipline of respondent's certificate pursuant to Code section, 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent, incompetent, or repeatedly negligent in his care and treatment of A. R., and his records were adequate.

Patient S. V.:

8. Cause does not exist for discipline of respondent's certificate pursuant to Code section, 2234, subdivisions (b), (c), or (d), or Code sections 2266 or 2261 because, as set forth in Findings 23 through 26, respondent was not grossly negligent, incompetent, or repeatedly negligent in his care and treatment of S. V., and his records were adequate.

Overall Assessment of Respondent's Care and Treatment of the Patients and His Documentation Concerning the Patients:

The only incident that involved gross negligence, and repeated negligent acts concerned patient W. D. In that case there was no evidence that respondent lacked the appropriate knowledge, skill or training to evaluate and treat W. D.; rather, it appears that the gross negligence and repeated negligent acts resulted from the busy, hectic, pace that existed in the hospital that day. Respondent accepted erroneous information he gleaned from a conversation with the radiologist concerning the location of the pneumothorax. Respondent should have taken the time to corroborate those findings before implanting the first chest tube. Then, respondent tried to conceal the mistake by making "accurate", but misleading, chart entries.

An overall review of these cases reveals a deficiency in respondent's documentation of patient assessment, care and treatment, however, presumably respondent has cured these deficiencies by having taken the UCSD PACE records keeping course (Finding 33.)

Overall, it appears that respondent is an excellent surgeon that made some significant errors in medical procedures and documentation concerning patient W. D., in 1998, three and one-half years ago. Respondent has no record of any other such acts. Accordingly, since cause for discipline exists, the question is, what level of discipline is necessary to protect the public and ensure that respondent that does not represent a present or future risk to patients. The ALJ believes that a short term of probation with appropriate terms and conditions will serve to accomplish those goals.

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Costs:

9. $15,000.00 represents the reasonable costs of the investigation and enforcement of the instant case against respondent, recoverable by the board pursuant to Code section 125.3

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A 40801 and Physician Assistant Supervisor Approval No. SA 27600 issued to respondent Festus Bamidele Dada are suspended for 180 days pursuant to Legal Conclusions 1, 2, 4, and 6, separately and for all of them. All suspensions shall run concurrently. However, the suspension(s) is/(are) stayed and respondent is placed on probation for one year upon the following terms and conditions[7]:

1. Within 15 days after the effective date of this decision respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

2. Within 60 days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during his one year of probation.

3. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and

[7] This Proposed Decision deviates from the disciplinary guidelines for the following reasons: 1) respondent has the background, training, knowledge and ability to perform within the standards of care, the problems with W. D. primarily arose as a result of the harried pace at the hospital; accordingly, requiring respondent to undergo further training is not required, nor appropriate, given the specific facts of this case. 2) Respondent has already attended to his record-keeping deficiencies by having taken the UCSD PACE record-keeping course. 3) the one-year period of probation provides sufficient time, within which, respondent can address the alteration of records/inaccurate records issue by taking and completing an ethics course.

remain in full compliance with any court ordered criminal probation, payments and other orders.

4. Respondent shall submit quarterly declarations under penalty of perjury on forms provide by the Division, stating whether there has been compliance with all the conditions of probation.

5. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code Section 2021(b).

6. Respondent shall, at all times, maintain a current and renewed physician and surgeon license.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California, which lasts, or is contemplated to last, more than thirty (30) days.

7. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

8. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

9. Upon successful completion of probation, respondent's certificate and Physician Assistant Supervisor Approval number shall be fully restored.

10. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. Respondent is hereby ordered to reimburse the Division the amount of $15,000.00 within 90 days from the effective date of this decision for its investigative costs. Failure to reimburse the Division's cost of its investigation shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by respondent shall not relieve the respondent of his/her responsibility to reimburse the Division for its investigative costs.

12. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

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13. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Said costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later that January 31 of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

Dated: April 8, 2002.

ROY W. HEWITT
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant



**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>FESTUS BAMIDELE DADA, M.D.<br>802 Magnolia Avenue, #203<br>Corona, California 91719<br><br>Physician's and Surgeon's<br>Certificate No. No. A 40801<br><br>Physician Assistant Supervisor<br>Approval No. SA 27600<br><br>Respondent. | Case No. 18-1999-101312<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about April 23, 1984, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 40801 to Festus Bamidele Dada, M.D.

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("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2001, unless renewed.

3. On or about August 27, 1997, the Medical Board of California issued Physician Assistant Supervisor Approval No. SA 27600 to Festus Bamidele Dada, M.D. ("Respondent"). The Physician Assistant Supervisor Approval was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2001, unless renewed.

JURISDICTION

4. This Amended Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), under the authority of the following sections of the Business and Professions Code ("Code").

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

7. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in

any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligence and Incompetence - Patient Walter D.)

12. Respondent Festus Bamidele Dada, M.D., is subject to discipline on account of his care, treatment and management of patient Walter D. The circumstances are as follows:

A. On September 14, 1998, patient Walter D. presented with a right pneumothorax. Respondent was asked to place a chest tube.

B. Without first conducting a sufficient examination of the patient and without reviewing the patient's x-ray, respondent placed a chest tube on Walter D.'s left side.

C. After completing the first procedure and leaving the operating room, respondent discovered the chest tube was to be placed on the right side, not the left side, so he undertook a second procedure and placed a chest tube on the right side. Respondent then changed the consent form by adding a "s" to make tubes plural. In addition, respondent changed the progress notes to indicate bilateral rather than right pneumothorax.

D. Five days later, respondent dictated an operative report and consult report that incorrectly stated related what had taken place.

E. When questioned by a peer review committee, respondent falsely told the committee that placement of the tube on the left side was appropriate because Walter D. had effusion on the left side.

13. Respondent Festus Bamidele Dada, M.D., is subject to disciplinary action in that he committed acts of gross negligence, repeated negligent acts and demonstrated

incompetence in violation of Code sections 2234(b), 2234(c), and 2234(d) in connection with his care, treatment and management of patient Walter D., in that:

A. Complainant realleges paragraph 12 above and incorporates it by reference herein.

B. Respondent failed to perform or document an adequate preoperative evaluation.

C. Respondent failed to review the chest x-ray prior to performing the procedure.

D. Respondent failed to remove the left chest tube even though it was unnecessary for the treatment of the patient.

E. Respondent failed to remove the unnecessary chest tube even though leaving it there caused the patient additional, unnecessary pain.

F. Respondent failed to obtain consent for placement of a second chest tube.

G. Respondent altered and falsified his progress notes to make it appear that the procedure was intended to be bilateral.

H. Respondent altered and falsified the surgical consent.

I. Respondent dictated an operative report that falsely made it appear as if a bilateral procedure was intended and that both tubes were placed during the same procedure.

J. Respondent failed to dictate an operative report that correctly set forth what had transpired.

K. Respondent dictated a consultation report that incorrectly described Walter D. as having a left pneumothorax and a right pleural effusion and falsely represented the plan of treatment as insertion of chest tubes.

L. Respondent falsely represented to the peer review committee that Walter D. had left side effusion making a chest tube appropriate for that side.

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## SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts and Incompetence - Patient Walter L.)

14. Respondent Festus Bamidele Dada, M.D., is subject to discipline in connection with his care, treatment and management of Patient Walter L. The circumstances are as follows:

A. On May 5, 1998, patient Walter L., 86 years old, was admitted to Inland Valley Regional Medical Center. A consultation by respondent on May 5 indicates that Walter L. was admitted to the hospital with fatty food intolerance, nausea and episodic abdominal pain radiating to the back. Respondent's consultation note mentions in past medical history that Walter had degenerative joint disease, a morphine pump implanted and chronic renal insufficiency. No mention is made of any other prior illnesses or surgery or of any medications that the patient was currently taking. For his review of systems respondent simply wrote "negative." As a for a physical examination, respondent noted only under chest that the lungs were clear bilaterally. For cardiac it says only S1 and S2.

B. A nurse prepared an "Initial Patient History Assessment" which stated that the patient had undergone coronary artery bypass graft in 1980 and again in 1987. He had a pacemaker inserted in 1998. He had blood pressure problems, cardiac arrhythmias and prior myocardial infarction. He experienced fainting spells, had a history of a stroke 3 years prior, had edema of the extremities and experienced shortness of breath on exertion. Medications at this time were Hydrolozine, Imdur, Lasix, Hytrin, Cordarone, Nitro patch, Synthroid, Inabsine and Lanoxin. The laboratory reports dated May 5, 1998, show creatinine 3.5, serum digoxin 2.7, INR 1.2, PTT 30, platelet count 99,000. An ultrasound of the abdomen performed on the same date was interpreted as showing gallstones.

C. The progress notes show an admitting note written by another physician. His comments are dehydration, renal insufficiency, history of HTN, history of TIA, thrombocytopenia, compensated congestive heart failure, admit, see orders.

Immediately following this is a progress note by respondent that says only: "surgery 1. cholelithiasis 2. history of DJD. Plan: lap. chole. possible laparotomy."

D. On May 6, 1998, respondent performed a laparoscopic cholecystectomy on Walter L. The operative report does not indicate any intraoperative difficulties, and describes a rather routine procedure. Several hours after the operative procedure, Walter L. was hypotensive. Respondent's progress note states the patient was "pale, moaning, blood pressure 78/20, rule out post op. bleed, to surgery ASAP."

E. The patient was returned to the operating room and underwent a laparotomy. He was found to have 600 cc's of blood in the subhepatic space and was bleeding from an arterial vessel adjacent to the cystic duct. The bleeding was controlled by electrocautery. Towards the end of the procedure, the patient developed cardiac arrest. Attempts at resuscitation and defibrillation were unsuccessful. The only indication of the patient's pulse is on the anesthesia record and is noted to be 60-70.

F. An autopsy was performed, and the report noted intra-abdominal hemorrhage, 1000 cc, 99% occlusion of the left anterior descending coronary artery and 98% occlusion of the circumflex coronary artery. The bypass grafts were 100% occluded.

15. Respondent Festus Bamidele Dada, M.D., is subject to disciplinary action in that he committed acts of gross negligence, repeated negligent acts and demonstrated incompetence in violation of Code sections 2234(b), 2234(c), and 2234(d) in connection with his care, treatment and management of patient Walter L., in that:

A. Complainant realleges paragraph 14 above and incorporates it by reference herein.

B. Respondent failed to perform or document an adequate preoperative evaluation.

C. Respondent failed to properly evaluate patient Walter L.'s postoperative hypotension.

D. Respondent failed to perform an EKG and determine central venous pressure prior to returning Walter L. to the operating room.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts and Incompetence - Patient Antonio R.)

16. Respondent Festus Bamidele Dada, M.D., is subject to discipline in connection with his care, treatment and management of patient Antonio R. The circumstances are as follows:

A. On October 30, 1997, 54 year old Antonio R. was admitted to the Inland Valley Regional Medical Center, with left sided abdominal pain intermittently present for six months unrelated to food. He had a long history of abnormal liver function tests, heavy alcohol use, and other illnesses consisting of hypertension, diabetes, depression, diabetic neuropathy and thrombocytopenia. He had ultrasonography of the abdomen performed that revealed cholelithiasis as well as a inhomogeneous liver echo consistent with diffuse liver disease. A CT scan of the abdomen again showed cholelithiasis[1]. There was a nodule in the right lobe of the liver, 2 cm. in size.

B. On December 8, 1997, respondent first saw patient Antonio R. for a surgical consultation in his office. Respondent noted the chief complaint of "gallstones" and reported the history that this was a diabetic male with symptomatic gallstones.

C. On December 9, 1997, Antonio R. was admitted to Inland Valley Regional Medical Center for laparoscopic cholecystectomy. Respondent prepared a very brief history and physical. It states that the patient had recurrent abdominal pain with fatty food intolerance. It identified as other medical illnesses asthma, diabetes and ulcer disease. Identified medications included insulin and Brontex. Respondent noted that his physical examination of the patient showed everything normal except for the abdomen, which respondent noted had right upper quadrant tenderness, no masses. Respondent recorded no vital signs.

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1. Cholelithiasis is the presence of gallstones in the gall bladder.

D. No blood tests were ordered by respondent in preparation for the surgery he was going to perform on Antonio R. on December 9, 1997. Instead, blood tests which were performed November 2, 1997, were reprinted on the day of surgery, December 9. Those blood tests showed elevation of the patient's liver enzymes, in particular very high elevation of the GGT, LDH and moderate elevation of the AST. His albumin was low at 2.5. Prothrombin time was minimally elevated at 1.1. Hemoglobin was 13.4 grams. Platelet count was 83,000.

E. At 12:40 p.m. on December 9, 1997, respondent started a laparoscopic cholecystectomy on Antonio R. At the start of the procedure, the patient's blood pressure was 130/90. Respondent's operative report states that intraoperative findings "include cirrhosis of the liver with a large amount of moderate collateral sac lesions in the umbilical ligament." The gallbladder was removed. Then "a liver biopsy was performed from the free edge of the right lobe of the liver and the site of the biopsy was then cauterized with electrocautery." There is no mention in the operative report of estimated blood loss or inspection of the abdomen for hemostasis.

F. The operation ended at 1:10 pm. The patient was taken to the recovery room. At 1:30 his blood pressure fell to 50-60 systolic and remained in that level until the end of the anesthesia record at 2:00. The anesthesia record notes that the patient was awake and extubated.

G. A new anesthetic record begins at 2:00 pm. This record indicates the surgeon was called at 1:30 when the patient became hypotensive. There is no indication when respondent returned the call. When the patient became hypotensive, he was given 500 cc of Hespan, 2000 cc of LR, Dopamine and epinephrine. At 2:15 the patient was reintubated, a subclavian central venous catheter was inserted as was a radial artery catheter. Blood pressure remained 50 systolic until 3:00.

H. The first blood work performed on the day of the surgery was done at 1:40 when the patient was hypotensive. Hemoglobin was 13.0 grams, platelets were

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99,000, arterial pH 7.33, base excess -.34. By 2:30 hemoglobin was 3.9 grams, platelets were 48,000, pH 7.3, base excess -11.5.

I. At 2:50 pH was 6.81, base excess -23. During this period of time he was given transfusions of O-blood, 8 units, as well as type specific on cross-match blood.

J. The patient was returned to the operating room and respondent performed a laparotomy. The patient was noted to be bleeding from the gallbladder bed, as well as from the liver biopsy site. Respondent's operative note states there was a blood loss of 2300 cc, a hand written note by the anesthesiologist states that the blood loss was 5000 cc. The restoration in blood pressure was transient. By 4:15, blood pressure, now by arterial line, was 80/40. At 5:30 the patient was taken from the recovery room to the Intensive Care Unit with a blood pressure of 90/50. Blood work at 6:00 showed his hemoglobin was 5.6 grams, pH 7.14, base excess -14.2. At 7:50, the patient's pH was 7.02, base excess -18.3, and at 21:00, his pH was 7.06 and base excess -18. The patient remained hypotensive and anuric throughout this period of time. At 10:45, he sustained a cardiac arrest and died.

17. Respondent Festus Bamidele Dada, M.D., is subject to disciplinary action in that he committed acts of gross negligence, repeated negligent acts and demonstrated incompetence in violation of Code sections 2234(b), 2234(c), and 2234(d) in connection with his care, treatment and management of patient Antonio R., in that:

A. Complainant realleges paragraph 16 above and incorporates it by reference herein.

B. Respondent failed to perform or document an adequate history and physical examination.

C. Before performing surgery on him, respondent failed to carefully evaluate whether the surgery was necessary and how Antonio's other medical problems would affect his operation.

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D. Respondent failed to obtain timely laboratory studies preoperatively.

E. At the end of the laparoscopic procedure, respondent failed to carefully assess the operative area to be certain that all bleeding had stopped.

F. Respondent failed to stop the bleeding at the liver biopsy site.

G. Respondent failed to properly transfuse the patient postoperatively.

H. Respondent failed to properly search for coagulopathy and attempt to correct his coagulopathy.

I. Respondent failed to timely return the patient to the operating room for further attempts to stop the bleeding.

J. Respondent failed to recognize that the patient had ongoing bleeding and failed to correct the consequences of ongoing bleeding.

K. Respondent failed to maintain adequate and accurate records relating to his care, treatment and management of Antonio R.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts and Incompetence - Patient Angelina B.)

18. Respondent Festus Bamidele Dada, M.D., is subject to discipline in connection with his care, treatment and management of patient Angelina B. The circumstances are as follows:

A. On or about June 11, 1996, patient Angelina B. presented to respondent for a surgical consultation regarding a lump on her right breast. Without performing or documenting a physical examination and without documenting the location of the lump, respondent scheduled her for a breast lumpectomy of the "inner" upper quadrant to be performed on or about June 26, 1996. On or about June 11, 1996, patient Angelina B. consented to the surgical removal of a lump from her "inner" upper quadrant.

B. On or about June 26, 1996, respondent performed and documented a history and physical reflecting a lump in the "outer" right quadrant of patient Angelina B.'s right breast. Respondent then performed surgery on patient Angelina B and removed

a lump from the "outer" upper quadrant of her right breast. Respondent did so without first obtaining consent.

19. Respondent Festus Bamidele Dada, M.D., is subject to disciplinary action in that he committed acts of gross negligence, repeated negligent acts and demonstrated incompetence in violation of Code sections 2234(b), 2234(c), and 2234(d) in connection with his care, treatment and management of patient Angelina B., in that:

A. Complainant realleges paragraph 18 above and incorporates it by reference herein.

B. During his initial examination, respondent failed to properly document the location of the breast lump.

C. Without first obtaining consent, respondent removed a lump from the "outer" upper quadrant of Angelina's right breast.

D. Respondent failed to cancel surgery even though he could not longer locate the breast lump for which surgery was to be performed.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts and Incompetence - Patient Scott V.)

20. Respondent Festus Bamidele Dada, M.D., is subject to discipline in connection with his care, treatment and management of patient Scott V. The circumstances are as follows:

A. Prior to September 7, 1995, patient Scott V. was referred to respondent for a surgical consultation regarding a non-healing ulcer on his right leg. On or about September 7, 1995, Scott V. presented to respondent for the consultation. At the time, Scott V. was suffering from and under treatment for peripheral vascular disease and hypercholesterolemia. His medications included Trentol. Respondent performed a history and physical limited to the ulcer, but billed for a comprehensive history and physical.

B. Respondent recommended a wide excision of the ulcer and coverage with a full thickness skin graft. Respondent performed that procedure on or

about September 11, 1995. In connection with the surgery, respondent harvested a 60 cm. donor site. Respondent's operative report does not identify the donor site.

C. The notes for respondent's October 17 and 24, 1995 examinations are illegible.

21. Respondent Festus Bamidele Dada, M.D., is subject to disciplinary action in that he committed acts of gross negligence, repeated negligent acts and demonstrated incompetence in violation of Code sections 2234(b), 2234(c), and 2234(d) in connection with his care, treatment and management of patient Scott V., in that:

A. Complainant realleges paragraph 20 above and incorporates it by reference herein.

B. Respondent failed to conduct or document a sufficient history and physical at the time of the consultation.

C. Respondent failed to conduct or document a sufficient history and physical at the time of the surgery.

D. Prior to surgery, respondent failed to consider whether Scott V. suffered from vascular disease

E. Prior to surgery, respondent failed to determine that Scott V. suffered from vascular disease.

F. Prior to surgery, respondent failed to assess Scott V.'s general health and ability to withstand and recover from the operation.

G. Prior to surgery, respondent failed to take or document Scott V.'s leg and foot pulses.

H. Respondent performed skin graft surgery for a vascular insufficiency ulcer in a patient with severe peripheral vascular disease.

I. Respondent harvested an excessive amount of skin for grafting.

J. Respondent failed to document the location of the donor site.

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SIXTH CAUSE FOR DISCIPLINE

(Dishonesty, Corruption and False Medical Records)

22. Respondent is subject to disciplinary action under sections 2234(e), 2261 and 2262 in connection with his care, treatment and management of the above identified patients in that he was dishonest and corrupt, he created false records related to the practice of medicine and he created false medical records and altered or modify medical records with fraudulent intent as set forth in paragraphs 12, 13, 14, 15, 18, and 19 which are incorporated here by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

23. Respondent is subject to disciplinary action under section 2234(e) in that was dishonest and corrupt in connection with his care, treatment and management of the above identified patients in that he failed to maintain adequate and accurate records as set forth in paragraphs 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21 which are incorporated here by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 40801, issued to Festus Bamidele Dada, M.D.;

2. Revoking, suspending or denying approval of Festus Bamidele Dada, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Revoking or suspending Physician Assistant Supervisor Approval No. SA 27600, issued to Festus Bamidele Dada, M.D.

4. Ordering Festus Bamidele Dada, M.D., to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

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5. Taking such other and further action as deemed necessary and proper.

DATED: April 19, 2001.

D. T. [signature], Chief of Enf. for
RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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